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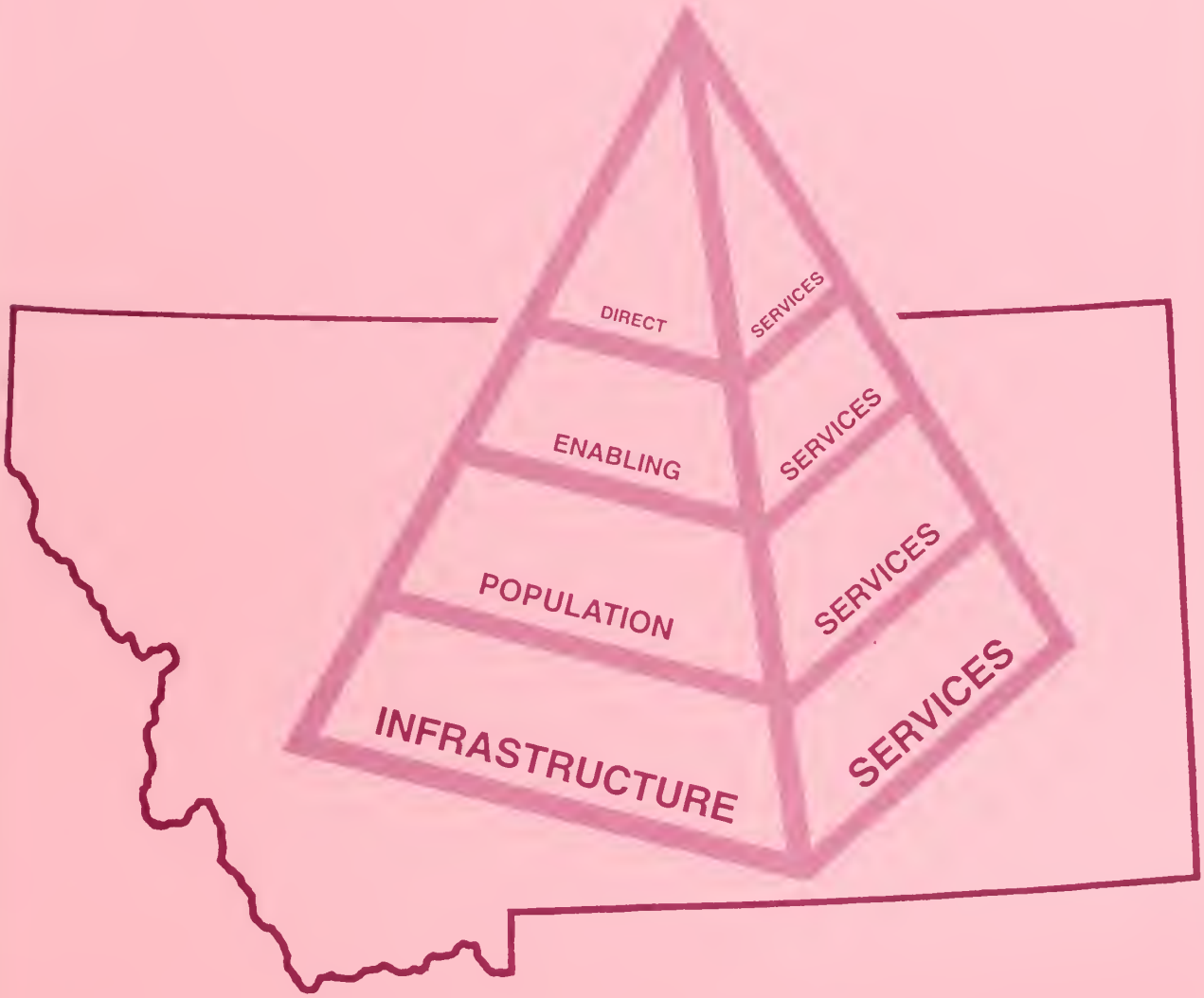
Maternal and Child Health Needs Assessment 2000



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Maternal and Child Health Needs Assessment

July 2000

Written by Marjean Heisler MPH

Family and Community Health Bureau
Health Policy and Services Division
Montana Department of Public Health and Human Services

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The staff of the Family and Community Health Bureau acknowledges Ms Heisler for her dedication and commitment to the needs assessment project.

Her excellent research and attention to detail have resulted in a document which will help guide Maternal and Child Health Services in our state.

Thank you - Marjean!

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Needs Assessment of the Maternal and Child Health Population

Needs Assessment Process

Assessing the health needs of the Maternal Child Health (MCH) population in Montana is an continuous process of gathering and analyzing data to establish priority needs. Statistical data for this needs assessment was gathered from several sources which are listed under "Resources" below. The data is primarily from the years 1995 through 1999. Input from stakeholders was received through surveys, and interviews with staff of related organizations. Public health provider input was received through regional meetings, focus groups, pre-contract surveys, and program statistics. Community collaboration was also solicited through focus groups around the state that were scheduled in conjunction with regional public health meetings. Data from calls made to the Montana "Health Mothers, Healthy Babies" 1-800 number also provided input to identify needs expressed by parents.

MCH needs assessment planning meetings were held at the state level to elicit input from county and state public health staff beginning in January of 1999. Information was also solicited from the Family and Community Health Bureau Advisory Council. The Advisory Council consists of persons representing a broad spectrum of concerned interest in maternal child health issues in Montana. The council includes representatives of health providers, parents, public health administrators, legislators, non-profit organizations, and various community health partners who are appointed by the Chief of the Family and Community Health Bureau.

Information in this report is organized based on four levels of public health core services as defined by the federal MCH Bureau. The four levels of service are infrastructure building services, population-based services, enabling services, and direct services. The federal MCH Bureau utilizes a pyramid symbol to show that the emphasis of the core public health services is to provide an infrastructure base upon which the other core services rely (see pyramid diagram below). The following section defines these four levels of core public health services.

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CORE PUBLIC HEALTH SERVICES

Direct Health Services

Enabling Services

Population Based Services

Infrastructure Building Services

Infrastructure Building Services are seen as the foundation of the other public health services. Infrastructure services provide support and increase coordination of health services. Examples of infrastructure services include: needs assessment, evaluation of services, planning, policy development, development of standards of care for services, monitoring, training, applied research, and data management through information systems.

Population-Based Services are broad-based programs aimed at the identification and prevention of health problems. Examples include public health screening programs such as the newborn screening programs, and lead screening programs. Also included in this category of services would be oral health prevention programs, SIDS counseling, nutrition education, and outreach.

Enabling Services are health services that attempt to increase access for all families to public or private health care systems. Examples of these types of services would be the provision of transportation, translation, health education, purchase of health insurance, (CHIP), WIC, and case management.

Direct Health Services provided by public health staff are defined as "gap filling" services. The majority of direct health services in Montana are provided by the private sector health care providers. Examples of direct health care services provided through public health staff would be a basic health service, such as a well child visit, provided by a public health nurse. Another example would be an immunization given by a public health nurse for a specific child when it does not occur at a public health immunization clinic sponsored for the public. Children with special health care needs also may receive direct services through public health sponsored clinics such as a cleft palate clinic.

This report will address each of the above four levels of core public health services related to four target populations within the MCH population. The four target populations addressed are:

- Pregnant women and infants
- Children and adolescents
- Children with special health care needs
- Women of childbearing age

Establishing Priority Needs

After gathering information on the needs of the MCH population the State must then analyze the data and prioritize needs. Performance measures allow the State to evaluate progress towards increasing the health of the MCH population over time. The Montana Department of Public Health and Human Services (DPHHS) began the process of setting and prioritizing performance measures based on a workshop directed by Ian Hill of Health Systems Research, Inc., under a contract with the U.S. Department of Health and Human Services Public Health Service in the summer of 1997. The conference was entitled "Data for Monitoring in State and Local MCH Programs in Montana." Various public health stakeholders across the state attended this workshop including local health department directors, public health nurses, the Title V officer, the Bureau Chief for Family and Community Health, and other State employees.

The workshop consisted of educational sessions on needs assessment strategies, performance monitoring and indicator development, resource allocation, and evaluation strategies for MCH programs. The list that was developed at this meeting was then circulated throughout the state to receive feedback on the recommended measures. The Family and Community Health Bureau Advisory Council met to develop a strategic plan that has also helped to establish priority state needs. A final list of state performance measures was developed by DPHHS and is found in Appendix A.

The Family and Community Health Bureau is currently contracting with an MCH epidemiologist to reexamine targets, improve methods of data collection, and assist with data analysis. The Bureau is also in the process of considering reallocating MCH Block Grant funds in order to make more efficient use of available resources and to equitably distribute funds based on changing population patterns across the state.

Resources

Resources Utilized for this report include 1998 Montana Vital Statistics, 1999 Youth Risk Behavior Survey (YRBS), the 1996 Montana Behavioral Risk Factor Surveillance System (BRFSS), the 1998 March of Dimes Community Perinatal

Needs Assessment, 1998 Montana State Health Profile, Montana Health Agenda, 1996-1998 Kids Count Data Books, Montana Census Bureau data, Healthy Mothers Healthy Babies, Baby Your Baby Final Report 1991-1997, the Montana Public Health Improvement Plan, Healthy People 2010, Indian Health Services website, 1998 Montana County Health Profiles, Congressional Quarterly State Fact Finder 2000, and various surveys and interviews conducted in Montana.

Strengths of the current methods

Strengths of the needs assessment methods include efforts to obtaining input from a variety of MCH stakeholders in Montana through surveys, interviews, and the participation of the Family and Community Health Advisory Council. Interns from various schools of public health have assisted over the past two years in the gathering of information, and provided valuable assistance to this effort.

Weaknesses of the current methods

In a large, predominately rural state it has been difficult to obtain universal participation of local communities in the MCH planning process. In 1999 the Family and Community Health Bureau decided to hold regional focus groups to elicit community input on MCH concerns. These were met with limited success due to low participation the initial year but will be continued. Another weakness is the lack of precise data on some issues. Montana is in the initial stages of developing an integrated public health data system that will improve the efficiency and accuracy of data collection.

Overview of the MCH Population

Demographics: Montana is the fourth largest state in terms of land mass in the United States with 94.1 million acres. The Census Bureau in the Montana Department of Commerce recorded approximately 882,779 people as residents in 1999. This gives Montana a population density of 6.1 individuals per square mile, classifying it as a frontier state. Due to the low population over a large area, great distances are often involved in accessing health care services. The state is made up of 56 counties, with approximately three-quarters of the state residing in the eight most populous counties.

Population Diversity: The largest minority group in Montana is the American Indian population, which accounts for approximately 6% of the total population. There are seven reservations within the state with approximately 56,000 American Indians. These reservations are home to the Blackfeet, Crow, Salish-Kootenai, Cheyenne, Assiniboine, Chippewa-Cree, Gros Ventre, Little Shell, and Sioux American Indians. Each tribe has unique cultural and linguistic practices. The following table from the Census department and Indian Health Services (IHS) illustrates shifts in population on and off the reservations among tribes from 1990 to 1998.

Reservation	1990 Census Pop.	1998 IHS Estimate
Blackfeet	8,549	8,643
Crow	6,370	10,615
Flathead	21,259	9,139
Ft. Belknap	2,508	3,567
Ft. Peck	10,595	7,536
N. Cheyenne	3,925	4,531
Rocky Boy	1,954	3,727

Montana has a very small percentage of African Americans and Hispanics. However, both populations, according to census data, are projected to increase and approximately double their population within the coming years. The following table illustrates the distribution of population by race/ethnicity within the state by the five health care regions.

RACE/ETHNICITY	PERCENT OF POPULATION					
	State Total	Region I	Region II	Region III	Region IV	Region V
White	92.7%	86.1%	84.2%	90.4%	95.8%	93.6%
Black	0.4%	0.2%	1.0%	0.4%	0.2%	0.2%
Native American	6.2%	12.0%	12.5%	6.2%	1.8%	4.2%
Hispanic	1.7%	1.4%	1.5%	2.5%	1.6%	1.4%
Other	0.6%	0.3%	0.8%	0.5%	0.6%	0.6%

Source: Census Bureau 1998

Other minority populations include migrant and seasonal farm workers. The Billings Migrant Health Center estimated that approximately 12,400 migrant workers and their families received health services in 1999 at the Billings clinic or one of six other satellite migrant health clinics across Montana. There are also approximately 300 Russians and 200 Southeast Asians in the Missoula area. Translator services have actively been pursued in these areas to assist in meeting the health care needs of immigrant and migrant populations.

Montana also has a population of approximately 3,000 to 4,000 Hutterites living in 30-35 colonies across the state. Hutterites are not specifically identified in census data. Hutterites are of German-European descent, and are often confused with the Amish. The Hutterites experience a high incidence of agricultural related injuries, especially to children, and this has become a health concern. Potential health issues for this population are related to health care practices, cultural isolation, and the potential for genetic disorders due to intermarriage.

Economics: The 1998 unemployment rate for Montana was 5.6% compared with a US rate of 4.5%. The average income for Montana residents was $20,082 in 1998. The Montana Department of Labor and Industry reports that Montana ranks 49th out of the 50 states for annual average wages. Reasons for this low ranking include lower hourly wages, a higher percentage of Montana workers working part time, and many Montanans working in industries where work can be seasonal.

According to the Congressional Quarterly State Fact Finder 2000, Montana is currently ranked 5th of the 50 states for the number of people in poverty. Approximately 17% of the population live in poverty in Montana. The state has one of the highest ratings of poverty in the northwest (Department of Labor and Industry, 1998). The goods-producing sector, which includes agriculture, mining, construction and manufacturing, contained 20 percent of the jobs in Montana in 1997. This is a decrease from 29 percent of jobs in the goods-producing sector in 1970. Service-producing sector jobs have been increasing since 1970 when 71 percent of all jobs were service related. Eighty percent of jobs were service related in 1997.

The economy in Montana has exhibited growth according to the state Department of Labor and Industry. Employment increased by 8,000 nonagricultural payroll jobs between 1997 and 1998 and per capita personal income rose nearly twice the rate of inflation during this time period.

American Indians in the Billings Service Area, which encompasses all the reservations in Montana and the Wind River Reservation in Wyoming, have the third highest percent of population below the poverty level (44.6%) relative to other IHS service areas in the US. This was reported by the IHS and is based on 1990 census data. The Billings Service Area also has the highest percent of unemployment for both males and females of the Indian Health service areas with males at 29.8 percent unemployed (age 16 and older), and females 21.0 percent unemployed (age 16 and older). The median household income for the Billings Service area was $14,249. Indian families below the poverty level are most likely living in sub-standard housing, have poor nutrition, and contend with hardships that are harmful to their health and well being.

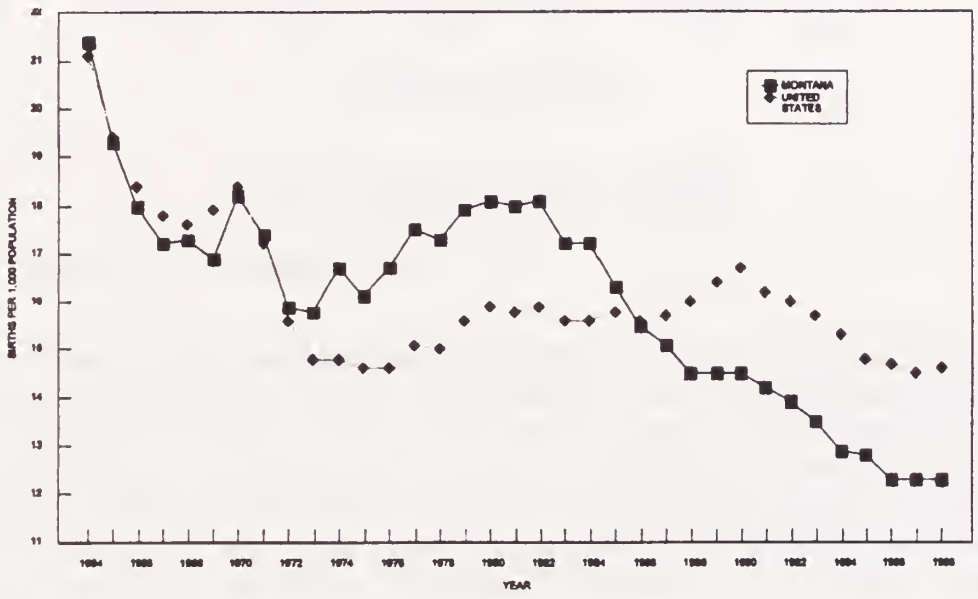
Shifts in Census: Shifts in census data provide important information for public health professionals, especially for a frontier state like Montana. The addition or subtraction of individuals from a county can have major impacts on the resources available in a community. The State population increased 10.2% from 1990 to 1998. Population growth in Montana however has been uneven over various parts of the State. Between 1990 and 1998 the Department of Labor and Industry reports that 34 Montana counties gained population and 22 counties lost population. The 17 counties that grew by more than 10 percent are in western and south central Montana. Most of the counties losing population are located in eastern and north central Montana. Fluctuations in the job market in Montana have also lead to dramatic population changes in some counties.

The following table shows the percent change in the top eight most populous counties from 1990 to 1998.

COUNTY	1998 POPULATION	% CHANGE '90-'98
Yellowstone	126,158	11.2%
Missoula	88,989	13.1%
Cascade	78,983	1.7%
Flathead	71,831	21.3%
Gallatin	62,545	23.9%
Lewis and Clark	53,655	13.0%
Ravalli	35,156	40.6%
Silver Bow	34,560	1.8%

Birth Rate The Montana birth rate for 1998 was 12.3 per thousand. This is one of the lowest rates ever recorded for the state, but part of a trend in declining birth rates since 1984. Montana birth rates have consistently been lower than that of the nation as a whole since 1986 (MT Vital Statistics, 1997). The following is a graph of the resident birth rates for the time period of 1989 to 1998, regardless of race.

Resident Birth Rates
Montana and the United States, 1964-1998

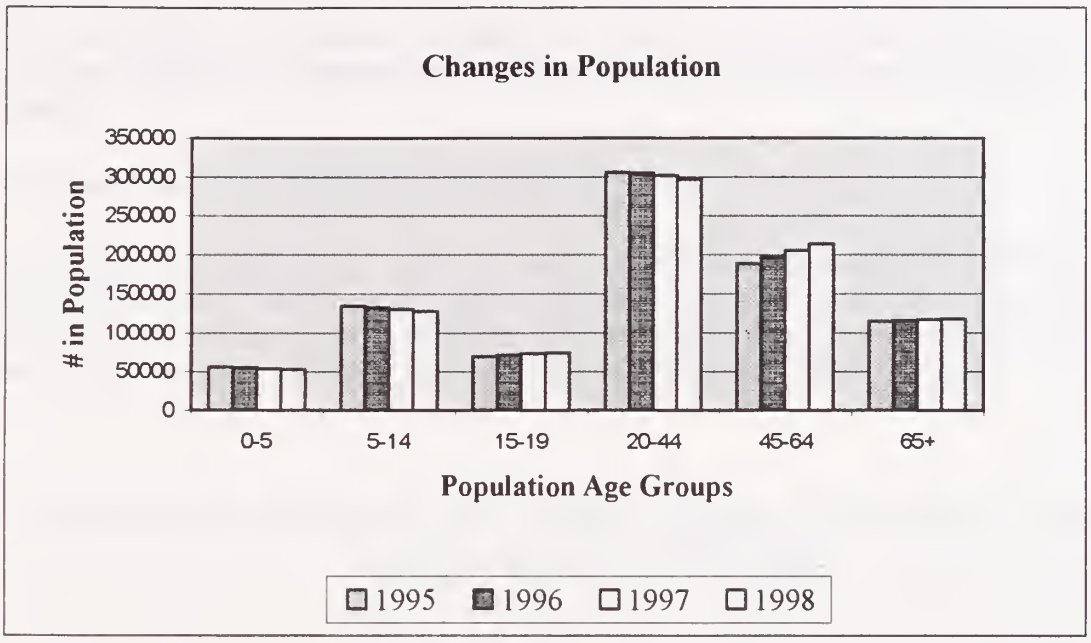


Source: MT Vital Statistics, 1998

During the 1980s, the out-migration of people in their 20's, resulted in a decrease in the number of births in the State. In the 1990s, there was an increase in the number of people aged 35-45 into the state. This later phenomenon resulted in an increase in school-aged children within the state. This flux in population may be related to the economy and the difficulty of obtaining a viable job in Montana for many younger persons.

Age Structure: According to census projections, Montana's proportion of adolescents is expected to decline. The state had the 12th largest proportion of adolescents in 1995. The proportion of adolescents is expected to decrease dropping Montana to the 40th of the 50 states by 2025. If this projection is correct a further decline in the birth rate would be expected.

Changes in specific age groups can be seen the graph below.



Source: Census Bureau 1998

It is of interest to note that Montana's dependency ratio (the ratio of youth under age 20 and elderly 65 and older, to adults age 21-64) is expected to increase to the 3rd largest in the nation in 2025, from where it was the 13th largest in 1995. This ratio will have consequence for women in Montana. Women have been socialized to take on the burden of caring for the young and elderly. Health practitioners can expect to see more women dealing with social issues related to family dynamics and the stress of increased care giving consequently as the dependency ratio rises.

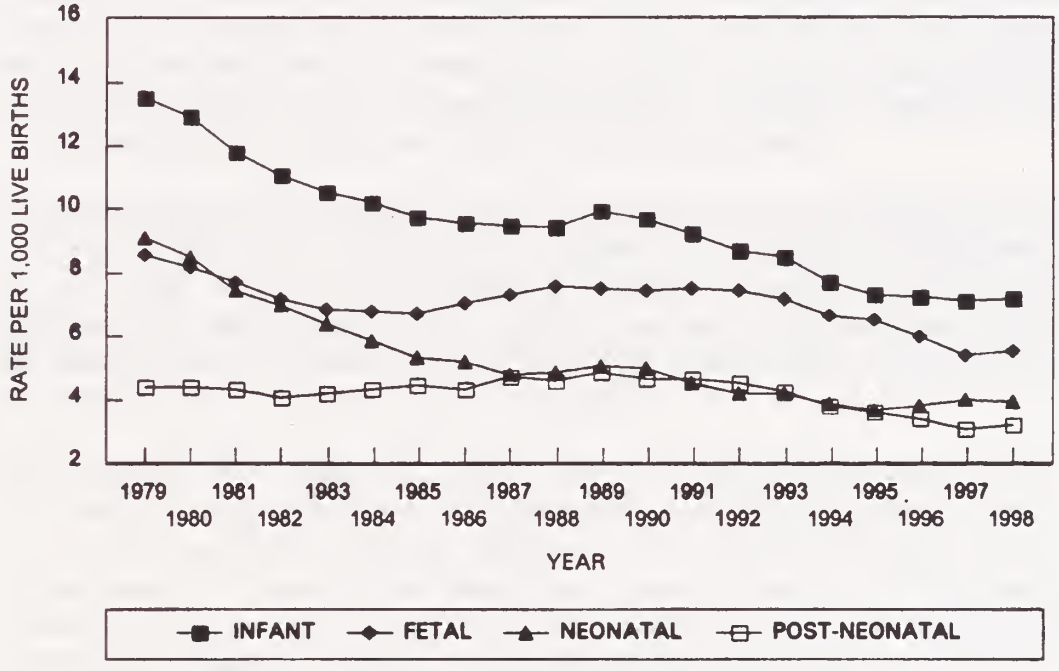
Health Status of the Montana MCH Population

The following is a synopsis of issues and health indicators that directly or indirectly affect the health status of each of the four MCH target population groups.

Pregnant Women, Mothers, and Infants

Infant Causes of Death: The infant mortality rate is defined as the number of infants that die before their first birthday per 1,000 live births. Below is a graph of mortality rates from 1989 to 1998 for infants in Montana. The overall infant mortality rate has decreased for newborns of all races since 1989.

FIVE-YEAR INFANT MORTALITY RATES AND FETAL MORTALITY RATIOS
Montana residents, 1979-1998



Source: MT Vital Statistics, 1998

Given the low population in Montana, statistics are most useful when looking at five years patterns since a small number of changes can produce disproportionate statistical results. The graph illustrates the five-year average for each given year. The infant mortality rate has shown an overall decline over the past two decades. The five-year infant death rate decreased from 13.5 infant deaths per 1,000 live births in 1979 to 7.2 per 1,000 live births in 1998 (MT Vital Statistics, 1/2000). This compares to a national infant mortality rate of 7.2 infant deaths per 1,000 live births for infants of all races in 1997 (HRSA, 1999).

The top five causes of death for infants, in order, (1995-1998) for all races in Montana were related to premature birth, congenital anomalies, unspecified other causes, SIDS, and unintentional injuries.

Fetal mortality is defined as the number of fetuses that die after 20 weeks gestation and prior to a live birth. The fetal mortality rate shows an overall downward trend since 1990. There were 7.0 fetal deaths in Montana per 1,000 live births in 1998. This ratio represents a total of 76 fetal deaths in 1998. The Montana five-year fetal mortality ratio in 1998 was 5.5 fetal deaths per 1,000 live births. This compares to a five-year rate of 8.6 fetal deaths per 1000 live births in 1979 (MT Vital Statistics, 1/2000). The year 2000 goal is 5.0 fetal deaths per 1,000 live births.

The Montana neonatal mortality rate (deaths in the first 27 days of life) for all races was 4.2 per 1,000 live births in 1998, compared to a national rate in 1997 of 4.8 deaths per 1,000 live births. The year 2000 goal for neonatal mortality in Montana is no more than 4.5 deaths per 1,000. The five-year rate of neonatal mortality in Montana was 4.0 deaths per 1,000 births in 1998. This compares to the state five-year rate of 9.1 deaths per 1,000 in 1979. Risk factors related to neonatal mortality include congenital anomalies, respiratory distress syndrome, short gestation, and maternal complications of pregnancy.

Postneonatal mortality is defined as infant deaths that occur after the first month of life through the 12th month of life. Congenital anomalies and SIDS are the two major causes of postneonatal deaths in Montana. There has been little change in postneonatal deaths from 1979 to 1998. Advances in perinatal care, and medical technology have decreased the number of neonatal deaths, allowing more high-risk infants to survive into the postneonatal period.

Montana has developed Fetal, Infant, and Child Mortality Review (FICMR) teams in an effort to reduce infant and child deaths. Currently, there are 16 local mortality review teams and one state team. The purpose of these teams is to review deaths in order to understand the causes of infant and child deaths in the state so that prevention efforts can be focused in a community to reduce deaths related to the specific causes. According to FICMR data these teams are reviewing approximately 80% of all fetal and infant deaths in the state.

Maternal Mortality: For the 1994-1998 time period, there were only two reported maternal deaths. There is concern about the accuracy of this figure, as it may not be based on a correct definition of maternal mortality. Maternal mortality occurs with a mother's death one year after the birth of a child. A common mistake is the belief is that a "maternal death" occurs only during childbirth, or soon after childbirth. The rate of maternal mortality in Montana is generally thought to be higher than what is reported. Discussions are ongoing about adding a check box to Montana's death certificate to identify women who have had a child a year

prior to their death. This will allow improved tracking and analysis of maternal mortality.

Low Birthweight: Infants born weighing less than 2,500 grams (5 pounds, 8.5 ounces), are considered low birthweight (LBW). Very low birthweight, (VLBW) is defined as an infant weighing less than 1,500 grams (3 pounds, 4.5 ounces). Low birth weights are associated with multiple potential health problems such as increased risk for infant mortality, chronic illnesses, developmental delays, and learning problems. The percentage of low birthweight infants has remained relatively unchanged over the past two decades in Montana despite a steady decline in infant mortality rate. The percent of low birthweight infants was 5.1 in 1990 and 6 per cent in 1997. The 1995 national rate for low birth weight was 7.3 per cent (Healthy People 2010 Objectives). There is a greater risk for low birthweight among unmarried mothers and mothers with less than a high school education according to MT Kids Count Special Report #1. The MIAMI (Montana Initiative for the Abatement of Mortality in Infants) program is a public health program that targets high risk pregnant mothers to continue to reduce the number of low birth weight infants. This program will be described further under health services for pregnant women and infants. As mentioned previously, advances in perinatal care, and medical technology have also led to an increased number of low birth weight infants born weighing less than 1,500 grams who are surviving.

Disparity: There continues to be disparity between the Caucasian versus American Indian population related to rates of infant mortality. The Billings Service Area of Indian Health Services (IHS) includes all seven Montana reservations and the Wind River reservation in Wyoming. The five-year Indian infant mortality rate in the Billings service area was approximately 10.9 deaths per 1,000 live births in 1995. This compares to a Montana rate for all races in 1995 of 7.1 deaths per 1000 births.

The major causes of infant mortality in the American Indian population have begun to change over the past decade. A 1997 report by IHS noted 25.67% of infant deaths from 1990-1992 among American Indians were due to SIDS in the Billings service area. SIDS was the leading cause of infant death among American Indians in Montana and Wyoming. From 1994-1996 the rate of death from SIDS among the same population decreased to 13.2% of infant deaths. The causes of infant death from 1994-96 in the Billings service area of IHS changed with 31.6% of infant deaths due to congenital anomalies, followed by SIDS, at 13.2%, and "newborn affected by complications of the placenta, etc." at 10.5 %. Staff from IHS speculate that the "Back To Sleep" campaign is one factor attributing to a decline in the number of reported SIDS deaths. Another factor may be the education of health professionals on the use of the diagnosis of SIDS and the requirement of an autopsy prior to labeling a death due to SIDS. There are differences in the birth rates between American Indians and Caucasians in Montana. The birth rate was 25.7 per 1000 population in the

Billings service area from 1994-96. The Montana all races birth rate for the same period was less than 13 per 1000. The number of women beginning prenatal care in the first trimester is estimated to be lower among the American Indian population. In 1994-96 IHS statistics show that 66.3 % of American Indian women in the Billings service area received first trimester care. This compares to a rate of 81% of women of all races in Montana receiving first trimester prenatal care based on a five-year average from 1993-1997 (1999 Montana County Health Profiles).

Another health concern is the number of mothers who report smoking or drinking during pregnancy in the American Indian population. Statistics from IHS for the Billings service area show that 7.5% of mothers report drinking during pregnancy. This compares to a U.S. rate of 1.5%. The percent of American Indian mothers who reported smoking was over 30% in the Billings service area in 1994-96. There are no statistics for women of all races in Montana that self-report smoking during pregnancy. The program for high-risk mothers in Montana, (MIAMI) does collect information on smoking however. The rate of smoking among high-risk pregnant mothers in Montana of all races participating in the MIAMI program was even higher than the IHS statistic at 40%. This compares with a U.S. rate of approximately 15% during 1995 for all races. It appears that smoking is a concern across all races in Montana.

American Indian women in the state were more likely to have a high birthweight infant than Caucasian women. High birth weights can be associated with gestational diabetes. American Indian women are twice as likely to give birth with diabetes as women of all races according to the 1997 IHS Report. Diabetes as a pregnancy risk factor is also associated with pre-term birth (less than 36 weeks gestation). In the Billings service area the birth rate with a diabetic mother from 1994-96 was 31.7 per 1000 births per IHS report. Statistics from Montana Diabetes Surveillance: An Analysis of Birth and Death Records, (January, 1996), report the rate of maternal diabetes among Caucasians was 1.9 percent during the period 1988-1994. The American Indian rate for gestational diabetes during the same time period was reported at 3.1%. These numbers were derived from birth records where diabetes was checked as a risk factor. The overall birth rate with diabetic mother in the US in 1995 was 2.5 %. The Billings service area rate of 3.1 % is lower than the rate for American Indian women in all IHS areas, which was 4.5 % in 1994-96.

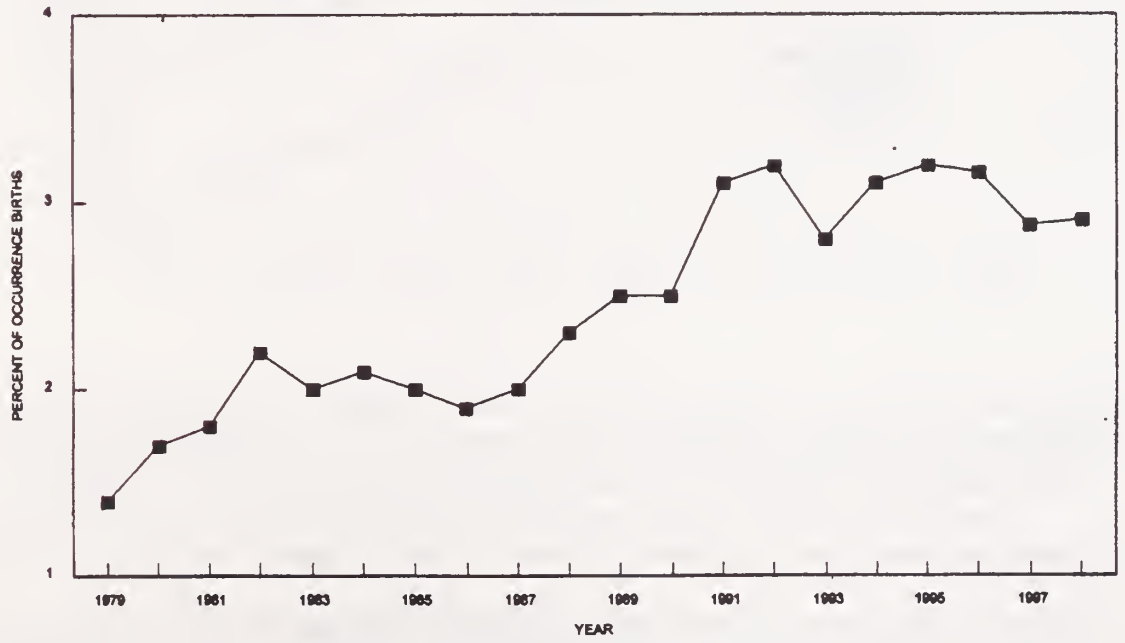
The current major issues of concern in the American Indian MCH population in Montana according to IHS staff and the Health Promotion and Disease Prevention Report include:

- Increasing the number of women receiving first trimester prenatal care
- Screening pregnant women for tobacco and substance abuse and providing follow-up
- Increasing well child visits for children

- Preventing obesity in children
- Reducing deaths from cancer of the uterine cervix
- Increasing the number of women who have annual Pap screening
- Reducing breast cancer deaths
- Increasing the number of women age 50-69 who have annual mammogram screening and breast exam

Delivery: Most births in Montana occur in a hospital. In 1998 less than 3 percent of births occurred outside the hospital setting. However, there has been an increasing trend of deliveries outside of hospitals in Montana since 1979. Direct entry midwives (DEM), were authorized to attend low risk pregnant women by the Montana State Legislature in 1989. The educational requirements for DEMs are outlined in the Montana Code Annotated and the Administrative Rules for Montana (37-27-320 {2}). DEMs are licensed under the Board of Alternative Medicine in the state and are subject to annual examinations. DEMs are required to report within 72 hours any incident that might have bearing on the mother's health to the Title V program director found within the Child, Adolescent, and Community Health Section of the Family and Community Health Bureau. The midwife must also report to the Board of Alternative Health Care regarding complications during the delivery. There is currently no over-sight system to determine if reporting is complete or accurate. The following graph illustrates the rise in the number of births occurring outside of hospitals from 1979-1998.

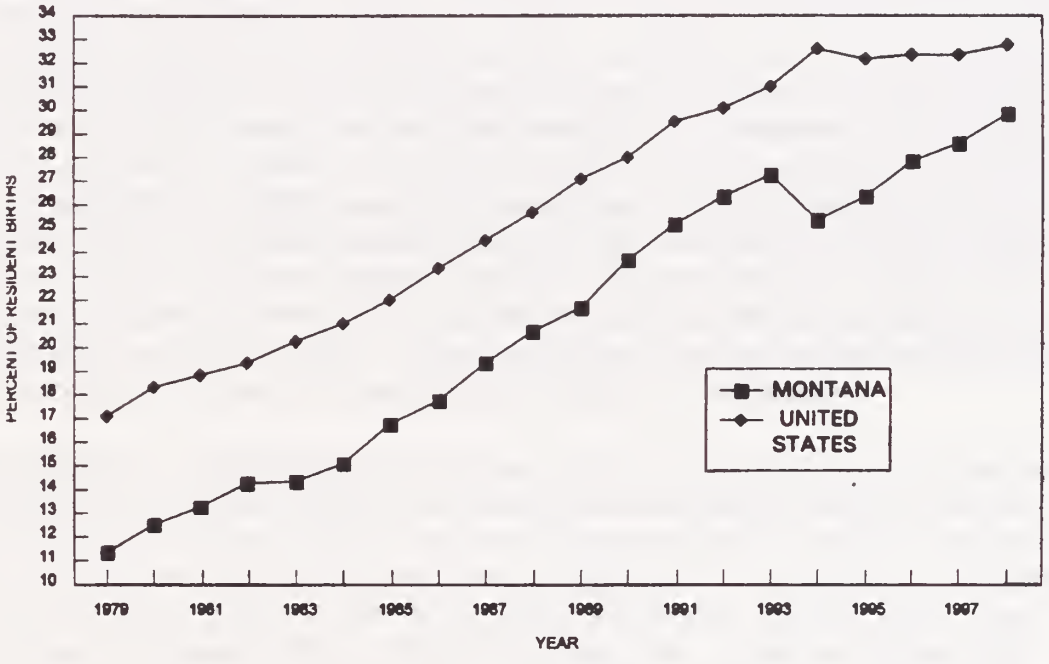
PERCENT OF BIRTHS OUTSIDE HOSPITALS
MONTANA OCCURRENCES, 1979-1998



Source: MT Vital Statistics, 1998

Pregnancy Rate for Unmarried Women: An issue of concern is the pregnancy rate for unmarried women. This is a particular concern within the younger women of the state, between the ages of 15-24. The pregnancy rate among unmarried women has been increasing since the 1980s. In 1997, it reached a high of 27.9%. The average rate in the US reported in 1995 demonstrated that 32% of live births occurred to unwed mothers (MT Vital Statistics). American Indian women were more likely to be unmarried during pregnancy than their white counterparts. Children of unmarried mothers are at an increased risk of having adverse outcomes. Unmarried mothers as a group, are less likely to receive adequate prenatal care, more likely to participate in behavior that may harm a fetus during pregnancy such as smoking or drinking, and are more likely to live in poverty compared to their married counterparts. The following is a graph of the percent of resident births to unmarried women from 1979 to 1998.

PERCENT OF BIRTHS TO UNMARRIED MOTHERS
MONTANA AND U.S. RESIDENTS, 1979-1998



Newborn Screening: Virtually all newborns in Montana are screened for inborn errors of metabolism—PKU, hypothyroidism, and galactosemia. Screening for hemoglobinopathies is being considered and a pilot program has begun. The State does not universally screen newborns for cystic fibrosis. There is continued debate related to the cost versus benefit of cystic fibrosis screening.

Management of the newborn screening program has been recently transferred to DPHHS Special Health Services (SHS) section, which will allow increased

continuity of care for those newborns needing follow-up services available through the SHS section.

Under discussion currently is the suggestion to add a hearing screening checkbox on birth certificate forms. A checkbox may heighten awareness of the need for hearing screening and may improve accuracy of data gathered. A survey of Montana hospitals estimates that 60% of infants born in 1999 were screened for hearing before they left the hospital. A weakness in the continuum of care however is the current lack of coverage by State Medicaid, or the children's health insurance program (CHIP), to provide assistance with the cost of hearing aids once a need is identified.

SIDS: SIDS is the sudden death of an infant less than one year of age that remains unexplained after a thorough case investigation including a complete autopsy, examination of the death scene and review of the clinical history. SIDS continues to be an issue of concern within the state and was mentioned earlier under the disparity section. There were 13 SIDS deaths per 10,000 live births in 1997 (MT Vital Statistics, 1997). In 1998 there were 7 deaths attributed to SIDS in Montana and 10,791 live births. The national rate in 1995 was 8.0 per 10,000 live births (Healthy People 2010 Objectives). DPHHS continues to provide education to the public about SIDS and on ways to prevent it—such as laying an infant on his or her back, removing any contact with sheepskin, and no smoking in the household. In 1998 and 1999, DPHHS received small grants for SIDS public education. A SIDS intervention guideline for Public Health Nurses was developed and is currently available through the Child and Adolescent Health Section of the Family and Community Health Bureau. DPHHS is also in the beginning stages of promoting a legislation effort that would mandate autopsies of infants who die from SIDS. There are still two counties within the State that do not mandate autopsies for deaths in which SIDS is suspected.

Breastfeeding: Breastfeeding is an issue championed among many organizations across the state. Breastfed infants usually have a healthier weight gain, and usually do much better in health related issues than their bottle-fed counterparts. WIC provides education and greatly encourages their new mothers to breastfeed. Montana's Child, which is a project of Healthy Mothers, Healthy Babies, also advocates for breastfeeding. DPHHS monitors the number of mothers that breastfeed as part of national performance measures, and also as one of the state negotiated performance measures. The percent of mothers who breastfeed is derived from the WIC population who reported breastfeeding their infants at six months of age. In 1996, the rate was 35.1%. This increased to 37.7% in 1998, which is close to the 2000 goal of 39%.

Prenatal Care: There is widespread agreement among MCH professionals that early and continuous prenatal care is positive and effective. Tracking of prenatal care can be difficult secondary to women changing providers and the lack of a unified health data system across the State. The American College of

Obstetricians and Gynecologists describe four functions of prenatal care: risk assessment, serial surveillance, health education, and psychosocial support. Montana utilizes the Kotelchuck Index to evaluate the adequacy of prenatal care participation. This index uses the number of visits a woman receives during her pregnancy, the gestation of the pregnancy at delivery, and the trimester in which care began to determine the adequacy of prenatal care participation.

The percentage of women who adequately participated in prenatal care improved from 71.6% in 1993-95 to 72 per cent in 1997, (Montana 1999 County Health Profiles). Montana has been striving to increase entry into early and continuous prenatal care for all pregnant women through public and private health care professional's efforts throughout the state.
Adequacy of prenatal care is one of the health status indicators utilized by the State to measure progress in providing access to prenatal care. Another indicator is the percent of women beginning care in the first trimester. The Healthy People 2000 goal for first trimester entry into prenatal care was 90%. The 1999 Montana County Health Profiles show that 81% of women received care in the first trimester based 1997 figures, which is the most current data year. Earlier entry into prenatal care helps medical staff to closely monitor the women's health behaviors, and educate the mother on risks associated with smoking or drinking during pregnancy. As mentioned earlier, forty percent of MIAMI clients have reported smoking while pregnant. This is likely an underestimate due to self-reporting methods. Montana currently monitors the percentage of mothers who report smoking and/or drinking during pregnancy in their performance measures. This number is derived from MIAMI data. MIAMI will be discussed further under the enabling services section of this report.

Health Status of Children and Adolescents

Child and Adolescent Mortality: The top five causes of death for children 1-14 (1995-1998) continues to be unintentional injuries, unspecified other causes, congenital anomalies, cancer, and homicide/suicide.

Unintentional Injury: A preventable cause of morbidity and mortality among children and adolescents is motor vehicle accidents (MVAs). In 1998, Montana had a death rate from MVAs of 22 per 100,000. Montana currently ranks 10th in the nation, with number one being the worst, in death rates from MVAs. Thirty-seven percent of deaths due to MVAs in 1998 were in the 15-34 year old age group (MT Vital Statistics).

According to Montana's 1997 Youth Behavior Risk Survey (YRBS), the State ranks higher than the US in several respects that contribute to higher rates of unintentional injuries. For example, 32% of Montana youth rarely or never wear a seatbelt when riding in a car. This rate, however, dropped to 23% on the 1999

YRBS. This compares to a national rate of 22%. On the 1997 YRBS, 47% of Montana youth reported riding in a car driven by someone who had been drinking alcohol in the past 30 days. This compares to a national rate of 39%. On the 1999 YRBS, 27% of Montana youth surveyed reported driving a car when they had been drinking alcohol. This compares to a national average of 15%.

Due to the rural nature of Montana, many younger people begin driving at an early age to assist with farm activities as well as to get to school and extra curricular activities. Montana roads can be treacherous under normal circumstances but become deadly when driven by inexperienced drivers or under abnormal circumstances. Efforts are underway in Montana to require a graduated driver's license.

Montana also has a high incidence of firearm injuries. Hunting is a popular State activity, and even considered by some to be a right of passage for the young. The death rate due to firearms was 13 per 100,000 in 1998. Twenty-three percent of firearm related deaths occurred in individuals between the ages of 1 and 24.

Poverty: The number of children living in poverty is a widely used indicator of child well being. Poverty is closely associated with undesirable outcomes in areas of health, education, emotional well being, and delinquency. (Kids Count Data Book, 1999). More than half of children in Montana live in rural counties, which is not a problem in itself, but when combined with poverty can lead to isolation and a lack of services. Isolation is a key issue for people living within rural or frontier counties. Families are separated by extremely large distances, thereby removing access not only to community support systems, but also to medical and mental health services. In 1996, the poverty rate for children age 18 or younger was 19% (Kids Count Data Book, 1999). This number is based on a family earning less than $12,931 for a family of one adult and two children in 1997 dollars. The Montana Office of Rural Health notes that in 1999 Montana was 7th in the nation for the percent of school age children living in poverty. In 1999, public health nurses noted on the pre-contract survey that they feel poverty has increased in their counties, which has caused an increased reliance on public health services. (See appendix B for the Pre-contact survey results).

The following is a table from the U.S. Census Bureau, March of 1998 which illustrates that poverty among Montana's children has worsened in the 1990's.

YEAR	% OF CHILDREN <19 AT OR BELOW 200% OF POVERTY	% OF CHILDREN <19 AT OR BELOW POVERTY WITHOUT HEALTH INSURANCE
1993-95	43.3	8.4
1994-96	48.1	7.9
1995-97	50.6	13.2

Uninsured Children: Estimates by State officials show there are 20,000 to 25,000 uninsured children in Montana. Of this it is estimated that 14,700 are at or under 150% of the federal poverty level. Of that number, 3,000-4,000 children are eligible for Medicaid. The federal-state children's health insurance program (CHIP) is able to cover approximately 10,000 children who are not eligible for Medicaid and whose family earns less than $20,050 per year based on a family of four. As of July 1, 2000, there were 6,598 children enrolled in the CHIP program. CHIP will be further discussed under enabling services.

Child Abuse/Neglect: The exact number of children experiencing abuse or neglect in Montana is not known because of inadequate reporting and a lack of definitive criteria establishing what constitutes abuse and neglect. Nonetheless, child abuse and neglect is a problem in Montana and there are several child abuse/neglect prevention organizations in the state. For example, the Montana Children's Trust Fund, which is under DPHHS for administrative purposes, funds activities for child abuse and neglect prevention, education, and support for parents, families, and abused or neglected children. The Children's Trust Fund will be discussed further under enabling programs for children and adolescents.

Another way in which Montana is trying to combat child abuse and neglect is through goals and benchmarks that were developed by the Governor's Interagency Coordinating Council (ICC) on Prevention. Their first goal is to reduce child abuse and neglect by promoting child safety and healthy family functioning. The ICC seeks to accomplish this by reaching the following benchmarks in Montana:

- By the year 2005, double the number of child care providers who have credentials in early childhood care and education
- By the year 2005, maintain the success rate of children receiving in-home services at 95%
- By the year 2005, increase the number of at-risk children receiving in-home services by 15%
- By the year 2005, increase the law enforcement reporting rate for incidents of domestic abuse to 80% of those who seek shelter-care services

Dental Care: Lack of access to dental care is a priority concern for Montana youth. DPHHS and its partners continue to attempt to improve access to dental care for the MCH population. A dental coalition was formed in 1999 to assist in this effort. Four working groups were formed to develop short term and long term strategies to improve dental access in Montana. There are shortages of dentists in some areas of the state and some dentist refuse to see Medicaid patients. On an analysis of calls received by Healthy Mothers, Healthy Babies, in 1998, dental access was the third highest area of need parents identified for their children. For a more complete view of this analysis, (see Appendix C). The Montana Council for Maternal Child Health surveyed approximately 40 core stakeholders in the fall of 1999. Dental access for children was listed as the second highest priority in the state, (see Appendix D). Healthy Mothers, Healthy Babies also completed a survey of Montana dentist in 1998 to assess dental needs. Survey results are located in Appendix E.

To date, reporting on dental MCH performance measures has been limited to information from selected sentinel schools. Hopefully, with the advent of the state integrated data project, IDEA, data will be more readily available at both the county and state levels on this issue. The DPHHS is also scheduled to have an on-site visit from the Association of State and Territorial Dental Directors in 2000.

The DPHHS provides a fluoride mouth rinse program to school-aged children across the state. Because of the higher prevalence of well water usage, this is a necessary service to insure children receive the adequate amount of fluoride to help prevent dental decay. In 1999 there were 51,576 children served by the Montana fluoride rinse program.

Immunizations: Immunization clinics are coordinated at the local level by public health nurses. The state rate of immunization in 1996 was 78.5% for children age 2 or younger. That rate increased by 10%, to 88.4% in 1998. The Montana year 2000 goal is to have 90% of children immunized.

Environment concerns: Montana environmental health concerns include exposure to lead. Lead can be ingested by children playing in or near a home where lead-based paint chips or dust are present. Most homes built before 1978 contain lead.

Lead exposure can also occur at the site of lead processing facilities, such as smelters. East Helena, MT is the location of a lead smelter. Lead contamination from the East Helena smelter has caused the site to be listed by the U.S. EPA as a Superfund site. Blood lead levels in East Helena children in 1975 was an average of 28 ug/dl. This level fell to 3.83 ug/dl by 1997 due to increased environmental controls. This compares to a national average blood lead level of 2.8 ug/dl to 2.7 ug/dl during the same time period. A survey of East Helena children in 1999 demonstrated that lead levels may again be climbing as an

average level of 5.7 ug/dl was found among 80 children tested. Testing will continue to see if these 1999 levels were an anomaly or the beginning of an upward trend. Lead screening will be addressed more in depth below.

In 1999 another environmental health concern began to be highlighted in Libby, a town in the northwest corner of Montana. Libby was home to a vermiculite mine for several decades. Asbestos dust from this mine, which closed in 1990, has been connected with respiratory illness among residents. Several hundred deaths have been attributed to asbestos produced and released by the mine. The state DPHHS and the federal government are presently investigating the health risks posed by asbestos from this mine.

The use of cyanide in mining also presents a potential health risk in Montana when ground water inadvertently becomes contaminated. Montana only recently banned the use of cyanide in mining operations.

In April of 1996 a Montana Rail Link train derailed 30 miles west of Missoula along Interstate 90 and near the Clark's Fork River. The derailment spilled 64.8 tons of chlorine, 17,000 gallons of potassium cresylate, and 85 pounds of sodium chlorate. Five hundred residents of Alberton, MT were evacuated from the hot zone and 300 people were treated for symtoms of potential chlorine/chemical exposure in nearby hospitals. The long-term effects of high levels of chlorine exposure in humans is unknown. Chlorine exposure can be associated with eye irritation and long-term respiratory problems. Residents in the Alberton area have complained of memory loss, chronic fatigue, and aching joints, which are ailments that are difficult to positively link with chemical exposure. The U.S. EPA, the Agency for Toxic Substance and Disease Registry, state DEQ, DPHHS, and local Missoula county health department are among the entities involved in addressing the health concerns of this spill. Studies and monitoring are ongoing.

Lead Screening: The Montana LEAD program has conducted blood lead testing in 39 of 56 counties and screening has also been undertaken on some Reservations. During 1998, lead screening was performed on 2,600 children in WIC clinics. Statewide about 2% of children have had levels above 10 mcg/dl, which indicates a problem. Ten percent have also been found to have levels greater than 6 mcg/dl, which indicates that there is a possible problem. All of the children found with elevated blood levels were residing in areas designated as Superfund sites. Follow-up care is provided to all children with elevated blood levels. Environmental clean up of sites is initiated for areas in which a child has tested positive for blood lead levels around 20 mcg/dl.

Most of the lead screening to date has focused on children 0-6 years old in the WIC program, but screening is available to all children less than 72 months of age when requested. Information shows that approximately three-fourths of the State's WIC population is enrolled in Medicaid. There are other high-risk Medicaid children and non-Medicaid children living in poverty who also need to

be included in the lead screening process. The lead program is currently trying to recruit more physicians to screen children and increase the awareness of the issues involved with lead poisoning.

Teen Pregnancy and Adolescent Sexual Behaviors: Of concern for the adolescent population is the teen pregnancy rate. In 1995, teens represented 14.9% of all pregnancies, 12.7% of all births, 26% of abortions, and 16.4% of all fetal deaths (March of Dimes). For 1998, the birth rate for youth aged 15 to 17 was 19.4 per 1,000 live births (MT Vital Statistics). According to the 1999 Montana County Health Profiles, the teen fertility rate, which is a 5-year average from 1993-1997, was 41 per 1,000. Montana ranks fourth in the nation, with number one being the highest, for the percent of reported legal abortions obtained by teenagers (MT Primary Care Office).

The 1997 fertility rate for Caucasian females age 15-17 was 14.7 per 1,000. For American Indian female's aged 15-17, the fertility rate was 75.0 per 1,000 (MT Vital Statistics). American Indian females show a higher risk for initiating late, or receiving no prenatal care, participating in negative health behaviors such as smoking or drinking during pregnancy, and are at a higher risk for having gestational diabetes, thus putting both mother and infant at risk. These issues influence the higher infant mortality rates seen in the American Indian population.

The table below shows Montana's youth compared to the nation as a whole on reported sexual behaviors. In 1997, 46% of Montana's adolescents reported being sexually active, but only 55% of these adolescents used a condom. During 1996, 46% of the reported cases of chlamydia occurred in 15 to 19 years olds. The table is from the 1997 Youth Risk Behavior Survey (YRBS), depicting sexual behaviors of Montana's youth.

Behavior	Percentage of Students Reporting Behavior					
	Grades 7-8		Grades 9-12		Native Am.	
	MT	US (1995)	MT	US (1995)	Res.	Urban
Ever had sexual intercourse	22	24	46	53	73	64
Had sexual intercourse with four or more people during their life	5	7	16	18	31	26
Used or whose partner used a condom during last sexual intercourse	58	58	55	54	46	42
No HIV/AIDS education	17	17	7	14	10	12

A plan to reduce teen pregnancy and sexually transmitted diseases (STDs) is addressed by the Governor's Interagency Coordinating Council (ICC). The goal

is to reduce teen pregnancy and STDs by promoting the concept that sexual activity, pregnancy, and child rearing are serious responsibilities. They plan to accomplish this by reaching the following benchmarks:

- By the year 2005, reduce the percent of 15-19 year olds who report ever having sexual intercourse to 43%
- By the year 2005, reduce the pregnancy rate for female 15-17 year olds to 27 per 1,000
- By the year 2005, reduce the birth rate for female 15-17 year olds to no more than 15 per 1,000

Related to the above plan, the state applied for and received a grant from the federal government for abstinence education. It is a five year funded grant. The State has designed the program as an education tool to provide adolescents with the skills to postpone sexual activity, and also to provide parents with better communication skills to help teach their children about abstinence. The purpose of the abstinence program is to reduce the number of teens who have engaged in sexual intercourse and to reduce the rate of pregnancies and sexually transmitted diseases. The involvement of parents, public officials, educators, health care providers, the religious community, community leaders, and the business community are sought in order to try to accomplish these goals. To date, the abstinence program has conducted two statewide campaigns that were positively evaluated, and has ten local projects in place focusing on abstinence-only education.

Adolescent Suicide: According to 1998 data, Montana had a suicide rate of approximately 16 per 100,000, which compares to a national rate of approximately 9.6 per 100,000 (MT Vital Statistics and Healthy People 2010 Objectives). Many of these suicides occurred among the youth. In Montana, suicide is the second leading cause of death among persons age 15-19. Montana ranks third in the nation for the number of suicides (YRBS, 1999). In 1998, there were seventeen youth between the ages of 10-19 that committed suicide in Montana. Seven of these suicides occurred in children age 10-14. The State Adolescent Health Coordinator notes that while youth suicides in the 15-19 year old age range have stabilized, the numbers are increasing among 10-14 year old youth. According to the 1999 YRBS, 19% of Montana youth seriously considered suicide, with 16% making a plan to attempt suicide, and 7% actually attempting it. Currently the State Adolescent Health Coordinator along with the EMS Director and other collaborators are working towards developing a psychological autopsy process to look at environmental factors that may be playing a role in these deaths. A steering committee was developed at DPHHS to combat the problem of teen suicide and began meeting in May, 2000. The committee will develop a plan to help local governments define and build their own suicide prevention programs. This will be a challenge as there are 15 counties in the State that have no mental health program located within the county.

A survey was sent out by the Adolescent Coordinator with questions as to whether or not communities across the state had any prevention, intervention, or post-vention resources to deal with suicide. Most respondents did not know of any resources in their community, and those that had resources had mainly intervention and postvention, rather than prevention. Much work needs to be done in this area if Montana is to see a decrease in its incidence of adolescent suicide. For survey results see Appendix F.

Substance Abuse: In Montana, during 1997, 23% of child mortalities under the age of 15 involved an alcohol-related motor vehicle accident. This was greater than the nation's rate of 21% (Kids Count). According to the 1999 YRBS, 86% of Montana youth reported drinking alcohol in their lifetime compared to a national rate of 80%. Fifty-eight percent of Montana youth also had had at least one drink of alcohol in the past 30 days, compared to a national average of 52%. In 1997 27% of students surveyed reported driving after drinking alcohol during the past 30 days. This statistic dropped to 23% on the 1999 student survey.

On a survey given to elementary school teachers in 1999, 24.8% estimated that they had students who smoked. In Montana's 1996 dental needs assessment, 23% of adolescents used smokeless tobacco, double that of the national average. According to the 1997 YRBS, 25% of students smoked, which is identical to the national average. The YRBS also found that 33% of Montana males surveyed used chewing tobacco.

The 1999 YRBS reported that 34% of high students used alcohol or drugs before sex. Twenty-five percent of Montana youth used marijuana during the past 30 days, compared to a national rate of 26% in 1997. Ten percent of Montana youth used any form of cocaine during their lifetime, compared to a national rate of 8%. Finally, 2% of Montana youth had ever injected any illegal drugs during their lives.

Mental Health: Montana continues to struggle with providing adequate mental health care resources, especially for Medicaid clients. With the dissolution of the managed care mental health plan for Medicaid patients in 1999, this has become a serious issue. This issue spans across all the age groupings, but is of special importance with the state's youth considering the high rate of teen suicide. Montana ranks sixth in the nation for the percent of population lacking mental health services according to the Montana Office of Rural Health, 1999.

Violent Crime: Also of concern is the state's growing violent crime rate. It is the fifth fastest growing rate in the country. Gangs and gang-related activity have begun to appear in Montana. For a ten-year period between 1985 and 1995, the violent juvenile crime rate increased 139% (Kids Count). The following table from the Montana Board of Crime Control record the percentage of crimes committed by sex and age for 1994-1997.

Female Crimes by Age	1994	1995	1996	1997
Less than 10	2.53%	2.14%	1.54%	1.22%
10-12	5.66%	7.89%	9.53%	7.31%
13-14	20.79%	26.31%	33.36%	26.30%
15	21.26%	21.65%	21.37%	27.70%
16	21.95%	23.12%	19.88%	22.17%
17	18.04%	18.90%	14.33%	15.80%
Male Crimes by Age	**1994**	**1995**	**1996**	**1997**
Less than 10	2.35%	3.23%	2.79%	1.82%
10-12	10.21%	11.39%	10.99%	9.35%
13-14	21.25%	25.25%	28.62%	24.17%
15	17.21%	18.47%	20.69%	20.53%
16	18.34%	20.12%	19.21%	23.80%
17	20.04%	21.54%	17.71%	20.35%

The following table, also from the Montana Board of Crime Control, is a comparison of adolescent offenses from 1994-1997.

	% REPORTED			
OFFENSE	**1994**	**1995**	**1996**	**1997**
Crimes against Persons	12.73%	13.20%	13.63%	14.66%
Crimes against Property	40.29%	40.27%	38.33%	36.68%
Crimes against Public Order	6.14%	7.31%	6.19%	6.31%
Crimes Against Public Admin.	4.89%	5.67%	6.08%	8.09%
Drug Offenses	4.91%	5.42%	6.85%	6.69%
Status Offenses	21.99%	20.64%	21.90%	22.01%
Other	9.05%	7.49%	7.02%	5.56%

Children with Special Health Care Needs

Disability Prevalence: Montana uses a broad definition of children with special health care needs to include children at high risk. Inclusion of "at risk" children has allowed services to be more inclusive. It is estimated that 18 % of children in the State have special health care needs. According to 1998 figures, 51,014 children were considered to have special health care needs.

Congenital Anomalies: The following is a table of the top seven birth certificate reported congenital anomalies for 1995 and 1996. This is not an unduplicated count, as some children may have had more than one anomaly.

	1995	1996
Heart Malformations	14	7
Other Circulatory/Respiratory Malformations	23	16
Other Urogenital Anomalies	20	11
Cleft Lip/Palate	11	25
Other Musculoskeletal or Integumental Anomalies	14	14
Down's Syndrome	10	11
Other Anomalies	82	53

Source: MT Vital Statistics, 1997

Special Health Services (SHS) and SHS Clinics: The SHS section of the Family and Community Health Bureau is the State Children with Special Health Care Needs (CSHCN) program. This section provides or supports several clinics across the state of Montana. These clinics include cleft/craniofacial, pediatric neurology, juvenile rheumatoid arthritis, metabolic, genetics, growth disorders, diabetes, and hemophilia clinics. In 1998, 57 specialty and subspecialty clinics were conducted serving 852 children in conjunction with private providers.

In addition to SHS there are services available to children with special health care needs through the federally sponsored Part C/Early Intervention program. The combination of programs work together to provide Montana infants and children with disabilities, and their families comprehensive and appropriate intervention services.

Additional information on programs and services for Children with Special Health Care Needs are presented under the Infrastructure Building Services section of this report.

Montana Medical Genetics Program: Children with special health care needs (CSHCN) are also served through the Montana Medical Genetics Program at Shodair Hospital. The program provides approximately 60 annual clinics around the state. This program is the only source of comprehensive prenatal genetic diagnosis and management of genetic high-risk pregnancies in the state. Shodair Hospital provided the following genetic services in 1997: 539 field clinics, 110 fetal pathological examinations, 990 examinations of cytogenic specimens, and 3,185 alpha-fetoprotein analyses.

Montana Birth Outcomes Monitoring System: The Montana Birth Outcomes Monitoring System (MBOMS) is a relatively new system which will assist in early identification and surveillance of newborns and infants with targeted birth outcomes. Other goals of the MBOMS include decreasing the incidence of birth defects through population and client specific education, and improved services to affected newborns to promote healthy outcomes. MBOMS was initiated through the assistance of CDC and will greatly increase the infrastructure

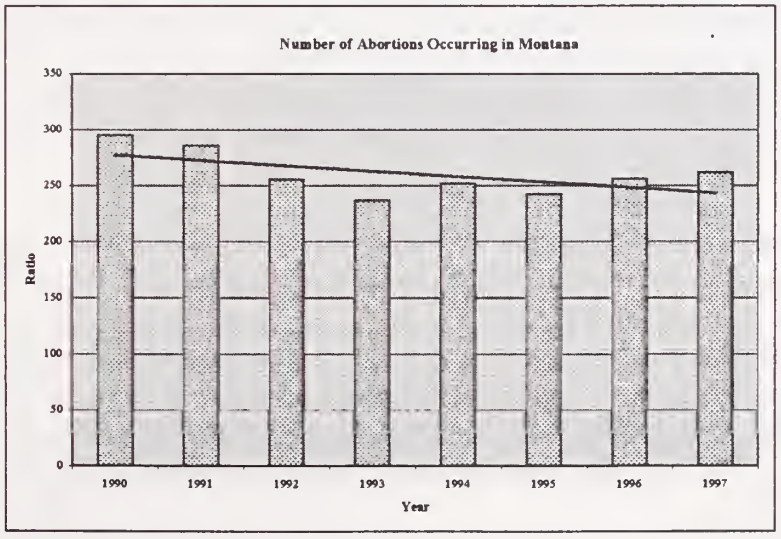
building capacity of the state and allow more children to be placed in follow-up services if a screen is positive for any defects.

Status of Women of Childbearing Age and Families

Causes of Death: The top five causes of death for white females of all ages (1995-1998) continue to be circulatory system diseases, cancer, chronic obstructive pulmonary diseases, pneumonia and influenza, and unintentional injuries. The top five causes of death for Native American females (1995-1998) are: circulatory system diseases, cancer, diabetes, unintentional injuries, and chronic obstructive pulmonary diseases, with chronic liver disease and cirrhosis very close behind.

Unintended Pregnancy: Unintended pregnancy is a cause for concern within this population. Infants from an unintended pregnancy are at an increased risk for low birthweight, poor growth and development, and abuse or neglect. Currently, the state medical officer is conducting a survey across the state on the "intendedness" of a pregnancy. It is estimated that in Montana more than half of all pregnancies are unintended—mistimed or unwanted, with that number being higher for adolescent pregnancies. According to the Women's Health Section of DPHHS, in the year 1997 statewide family planning clinics prevented an estimated 18,680 unplanned pregnancies. This prevented an estimated 12,573 unplanned births, 2,679 abortions, and 3,412 miscarriages.

Montana monitors the rate of unintended pregnancy as one of the MCH Block Grant State negotiated performance measures. The rate of unintended pregnancy was 69% in 1997, 67% in 1998, and the 2000 objective is 63%. The rate of unintentional pregnancy is closely tied to the abortion rate. The following graph depicts the number of abortions that occurred in Montana from 1990 to 1997.



Source: MT Vital Statistics, 1997

Domestic Violence: Domestic violence is a significant issue in the State of Montana. There have been several things done within the past few years to help combat this problem. The Montana Coalition against Domestic and Sexual Violence (MCADSV) assists victims of sexual and domestic abuse in many ways. The MCADSV provides training programs for professionals, operates a hotline for victims of abuse, and helps victims find shelter, counseling and other needed services. The MCADSV serves 55 of 56 counties in Montana providing safe homes, shelters and hotlines.

The Montana Domestic Violence Batterer's Intervention Program (MDVBIP) is a panel of practitioners and experts from related fields that have developed standards for batterer's intervention programs. The provision of standards allows improved quality assurance and evaluation of programs.

Montana has begun in recent years to request that county public health offices screen their clients for domestic violence as one of their state negotiated performance measures within the MCH Block Grant. The 1999 pre-contract survey showed that only 50% of counties are screening for domestic violence currently. For a clearer picture of domestic violence in the state, see Appendix G. The report in Appendix G is a needs assessment on the issue of domestic violence in Montana and was written by a Graduate Student Intern who worked with FCHB in the summer of 1999.

Substance Abuse: According to the Addictive and Mental Disorders Division, in a 1997 study, alcohol abuse was determined to be the most pervasive drug problem in Montana. In their study of 3,144 women sampled from the general population, approximately 21% of 18-24 year old women indicated that they currently have a substance use disorder. This result can then be viewed in correlation to MIAMI data on high-risk pregnant women that reveals higher rates of substance abuse during pregnancy. It is also noted that cigarette smoking among females in the state is also increasing, especially among the Native American population. On a survey given to elementary school teachers in 1999, it was estimated that 50% or more of school children are exposed to smoking in their home.

Family Planning: There is a continued need for increased family planning services in Montana. It is estimated that of 46,570 women in need of subsidized family planning services in Montana, 35% (16,093) did not receive services in 1998. In Montana, family planning is one component of the Women's Health Section of the Family and Community Health Bureau. This section administers Title X federal funding for the provision of family planning. Family planning services are directed towards achieving the following goals:

- Improve and maintain the emotional and physical health of men, women, and children, particularly through the detection and prevention of cancer and sexually transmitted diseases
- Reduce the incidence of abortion by preventing unplanned pregnancies
- Improve pregnancy outcomes by correction of health problems between pregnancies and by proper spacing and timing of pregnancy
- Assure that more children are "wellborn" by decreasing the incidence of prematurity and birth defects
- Decrease maternal and infant mortality and morbidity
- Assist couples who want to have children but cannot
- Prevent unplanned pregnancies (particularly in child abuse and poverty situations)
- Assist couples in having the number of children they desire so that every child is intended and loved

In 1998, family planning held 348 educational sessions across the state, and 10,038 people attended. Currently, the Women's Health Section is working on a plan that would extend the time a woman is eligible for family planning services covered by Medicaid to six months after she delivers her child.

Sexually Transmitted Diseases (STD): The incidence of STDs is a public health concern. The following table shows the prevalence by year of the top four reportable STDs in the State from 1995-1998

YEAR	AIDS	CHLAMYDIA	GONORRHEA	SYPHILIS
1995	37	1,220	69	19
1996	46	1,228	38	4
1997	47	1,208	67	5
1998	NA	1,414	NA	0

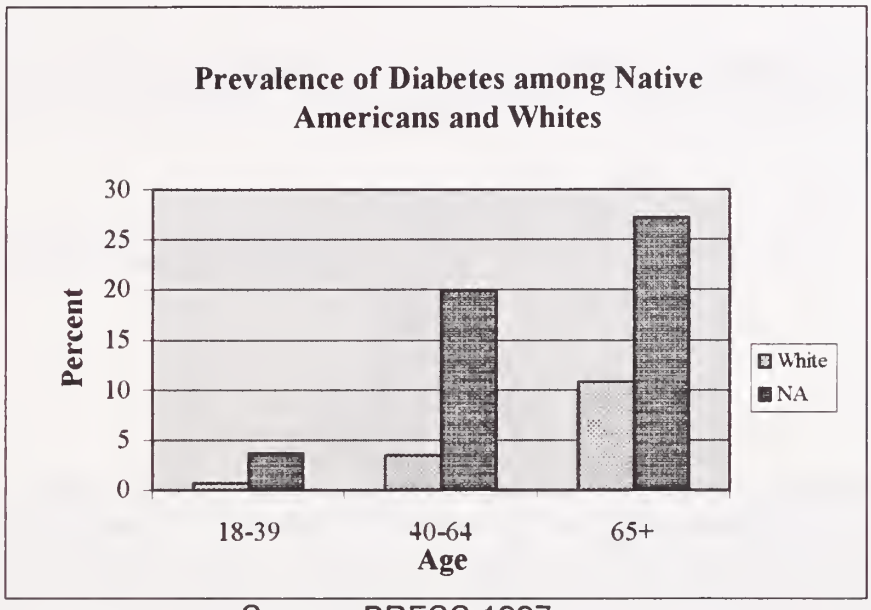
Source: MT Vital Statistics, 1997 and AIDS/HIV Bureau Data

A high chlamydial rate can indicate risk factors for other STDs and can serve as a surrogate marker to the number of individuals having sex without a condom. The following table compares the national rate of chlamydia versus the state rate, and also shows the different rates in the state health planning regions. When separated by region, disparities become visible. There are a higher percentage of minority populations in Region 1 and II.

Year	Laboratory-Confirmed Chlamydia Case Rates (per 100,000)						
	Nation	State	Region I	Region II	Region III	Region IV	Region V
1994	188	179	176	215	204	123	150
1995	189	152	137	237	160	120	113
1997	130	137	170	217	144	94	112
1998	NA	161	168	296	161	113	123

Source: AIDS/HIV Bureau Data

Disparities in Diabetes Diagnosis: American Indians in Montana experience a higher incidence of diabetes than do any of the other races within the state. The following graph is from data received from the 1997 Special Survey of the Behavioral Risk Factor Surveillance System (BRFSS), revealing the higher prevalence of the disease for those respondents residing on or near a reservation.



Source: BRFSS 1997

The discrepancy in diabetes rates raises issues of concern for American Indian women in the childbearing years.

Other Women's Health Issues: Other women's health concerns in the state include increasing the awareness and prevention of breast and cervical cancer. The State family planning clinics provide breast and cervical cancer screening for any client receiving prescription contraceptives at the clinics as part of Title X requirements. Follow-up on abnormal pap smears is initiated by the clinics. Women age 50-64 years are addressed through a state breast and cervical cancer prevention program funded by CDC.

Prevention of osteoporosis is another important health concern. The Women's Health Section of the Family and Community Health Bureau recently assessed the needs of providers on the provision of information on osteoporosis prevention. Based on results of this survey they developed an informational brochure available to family planning clinics.

HEALTH CARE SERVICES

The following section will describe public health services available in Montana and state priority concerns for each of the four core public health service areas.

Direct Health Care Services

The private sector medical community in Montana primarily provides direct health care services. State public health providers such as public health nurses also provide direct services that fill some of the gaps in health care to increase access to health care for all women and children in Montana. The following is a list of state priority concerns related to the availability of direct health care services in Montana.

- Lack of health care due to financial barriers
- Health care professional shortages
- Large physical distances to reach providers/specialists
- Lack of dental care access throughout the State
- Lack of access to mental health care

The following tables describe examples of direct health care services in Montana provided through public health programs that serve to fill gaps in direct care for each target population

Pregnant Women and Infants

Program	Target Group	Eligibility	Program Description	Provider
Well-Baby Checks	Infants	None	Medical professional exams to check proper development, etc.	PH Nurse
Prenatal Care	Pregnant women	None	Any direct service or procedure provided to a pregnant woman	PH Nurse

Children and Adolescents

Program	Target Group	Eligibility	Program Description	Provider
Well-Child Checks	Children 1-21	None	Medical professional exams to check proper development, etc.	PH Nurse
Migrant Children's Health Care	Migrant Children 1-21	Migrant Child	Program to provide migrant children with health care checks	Clinic Health Staff
Dental Care (Medicaid)	Children 1-21	Medicaid recipient	Program that provides dental care check-ups for children on Medicaid	Dentists

Children with Special Health Care Needs

	Target Group	Eligibility	Program Description	Provider
Part C/Early Intervention	CSCHN 0-3	Dev. Delay or, disability	Early intervention program providing support for parents with children eligible for the program; multiple services provided	Multiple: PT, OT, ST, Social Worker etc.
Cleft Palate Clinic	CSHCN	Medical	Clinic providing care, education, and referral to other services for children with cleft palates	Multiple: MD, specialist, case mang.
Metabolic Outreach Clinics	CSHCN	Medical	Clinic providing care, education, and referral to other services for children with metabolic disorders	Multiple
Neurologic Disorders Clinics	CSHCN	Medical	Clinic providing care, education, referral to other services for children with neurologic disorders	Multiple
Juvenile Rheumatoid Arthritis Clinic	CSHCN	Medical	Clinic providing care, education, and referral to other services for children with juvenile rheumatoid arthritis	Multiple
Home-Based Clinical Care	CSHCN	Medical	Program that provides needed equipment (tube feeders, ventilators, etc.) for families	Multiple
Genetics Clinics	CSHCN	Medical	Clinic providing care, education, and referral to other services for children with genetics disorders	Multiple: Specialists

Women of Childbearing Age

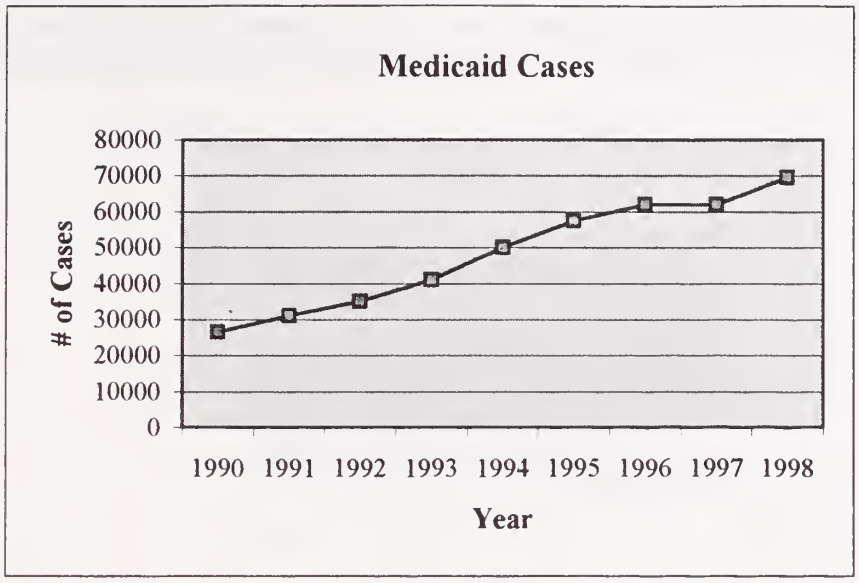
	Target Group	Eligibility	Program Description	Providers
Direct Family Planning Services	Women 15-44	None	Program that provides certain services (breast exams, pap smears, etc.) for women	Nurse, MD

FINANCIAL BARRIERS

Financial barriers to direct health care services have been listed as an area of concern in surveys of public health nurses. An analysis of calls to the Healthy Mothers, Healthy Babies 1-800 number also identified financial barriers as an issue of significance. In Montana an estimated 16.4 % of the population are at or below the poverty level according to the US Census Bureau 3-year average for 1996-98. The Census Bureau also estimates that 28% of children under age 5 in Montana live in poverty based on 1996 data. The Median Household income in Montana is $22,988 according to the 1990 census.

Medicaid is the largest provider of health care coverage for children in the State of Montana. Medicaid covered 62,047 children in 1997 according to a Medicaid program report submitted to the Montana State Legislature. Of the Medicaid recipients in 1997, 59.7 % were children, but expenditures for children accounted for only 20.4 % of total Medicaid cost . The majority of expenditures (73.7%) went for services to the blind and disabled, or aged. Low-income pregnant women are also eligible for Medicaid. The program limit is $3,000 per pregnancy and the income limit is based on 133% of the federal poverty level.

Medicaid has seen an increase in cases over the past few years. In 1995, Medicaid had approximately 57,000 cases. As of February 1999, there were approximately 70,000 Medicaid cases. The graph below illustrates the rise in Medicaid cases from 1990 to 1998.



Source: MT Statistical Report, February 1999

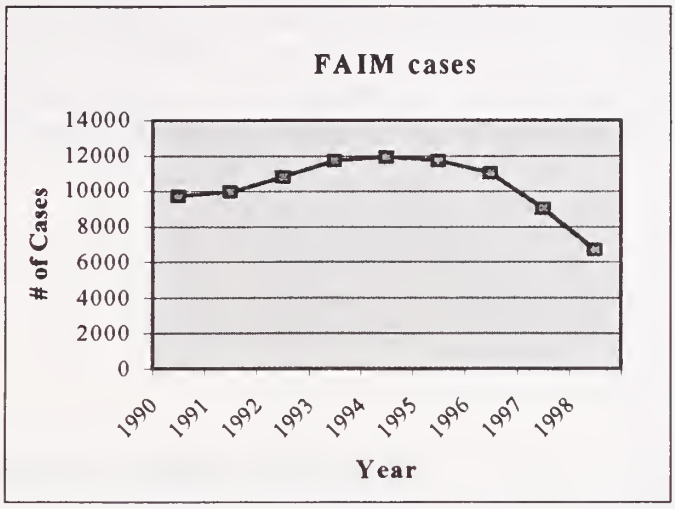
Medicaid eligibility varies by income. Children up to age 19 whose family income satisfies Temporary Assistance of Needy Families (TANF) criteria are eligible for full Medicaid coverage. Family income must be below 40.5% of the Federal poverty level to meet TANF criteria. Families with an income at or below 133% of the federal poverty level are eligible for full Medicaid coverage for children up to 5 years of age. The federal OBRA 89' legislation requires all states to implement either full coverage or to "phase in" coverage for children age 6-18 years whose families were at 100% of the federal poverty line or below. Montana chose to "phase in" children age 6-13 years in 1997. By 2002 Montana will cover all children 18 years and under in families earning up to 100% of the federal poverty level.

Medicaid in Montana provides reimbursement for medical services rendered to Medicaid eligible American Indians who receive health care services through IHS facilities or contracted providers. The reimbursement to IHS for Medicaid services has grown from 4 million in 1993 to 15.8 million in 1998 inclusive of all age groups.

Several changes occurred in Montana Medicaid over the past five years. The Families Achieving Independence in Montana (FAIM) program was implemented in 1995, which is Montana's welfare reform program. FAIM resulted in reducing the number of individuals on welfare. FAIM however did not change service coverage for children, pregnant women, the elderly, or disabled.

According to the Montana Statistical Report (February 1999 edition), FAIM resulted in decreases in welfare rolls. In 1995, Montana had approximately 11,700 individuals receiving welfare benefits through FAIM. As of February 1999,

this number fell to approximately 5,300 . The following is a graph of individuals receiving welfare benefits for the time period of 1990-1998.



Source: MT Statistical Report, February 1999

Also in 1995 the Medicaid HMO program was implemented for AFDC recipients in counties where HMO's exist. As of May 1997 there were four participating HMO's in the State. In 1996 Medicaid departmental reorganization was implemented to decentralize the administration of the program and created divisions responsible to specific populations.

It should also be noted that under the federal Early Periodic Screening, Diagnosis, & Treatment (EPSDT) legislation, states are required to provide children with any medically necessary service regardless of whether that service is part of the state Medicaid package of approved services. In Montana EPSDT is administered under the Medicaid program. According to the FY 1999 EPSDT Participation Report a total of 40,251 individuals under age 20 were eligible for the EPSDT program. In FY 1999 a total of 27,572 EPSDT visits were received by individuals.

The Children's Health Insurance Program (CHIP) state plan was submitted in 1998. This program provides funds for premiums to purchase insurance for children 18 and under who meet financial eligibility and are not eligible for Medicaid. Outreach for the CHIP program is predicted to increase the number of children on Medicaid. This program will be discussed further under the Enabling Section that follows.

AVAILABILITY OF HEALTH CARE IN MONTANA

Distribution of health care providers varies greatly across the state. In December 1999 there were 10 counties that did not have any primary care physicians. In addition 12 counties had a ratio greater than 2000:1 of population per primary care physician (see map 1 in Appendix H of this report). There were 22 counties

that were designated medically underserved in the same time period. Another 12 counties also had partial county designation (see map 2 in Appendix H).

Montana has a limited number of pediatricians and OB/GYN's with most of these located in the counties of Flathead, Missoula, Lewis & Clark, Cascade, Gallatin and Yellowstone (see map 3 and 4 in Appendix H). In December of 1999 there were 88 Pediatricians practicing in the state including sub-specialties and 88 OB/GYN's.

ENABLING HEALTH CARE SERVICES

Health care services that are classified as "enabling", are services that increase access for women and children to health information and providers. Examples of enabling services in Montana are presented in the tables below.
Priority State concerns in this category are:

- Increasing the number of children that are covered by health insurance
- Continuing to provide and expand outreach to "at-risk" pregnant women
- Continuing to provide and expand services to "at-risk" children and families

Pregnant Women and Infants

The following table is a list of the enabling programs and resources provided for pregnant women and infants.

Program	Target Group	Eligibility	Program Description	Provider
WIC	Pregnant women infants, children	Medical/ Nutritional risk, finan. criteria	Nutritional education, food supplements, breast feeding education, lead screening, referrals to health care providers, federally funded	WIC Staff
MIAMI	Pregnant women	High risk pregnant woman	Program that addresses the barriers to the reduction of infant mortality (prenatal care, medical care, etc.)	PH Nurse, SW, Dietician
Follow Me	At risk infants 0-1	At risk infants for biological, develptl,or envtl factors	Intensive home visiting and targeted case management program	PH Nurse, SW, Dietician
SIDS Follow-up	Infants 0-1	None	Follow-up program after a SIDS death provides parental support, education	PH Nurse

Maternal and Infant Nutrition (WIC): WIC provides nutritional education, food supplements, and often serves as the catalyst to entry into other needed health care services. At present there are 107 clinics across the state. These clinics provide WIC services to all 56 Montana counties and 7 reservations. They average a monthly caseload of approximately 21,500, which includes approximately 5,000 women, 4,300 infants, and 12,300 children. There were an estimated 35,600 potentially eligible women, infants and children statewide in SFY 1998 according to the WIC website: {http://www.dphhs.state.mt.us/hpsd/pubheal/healsafe/nutritn/overview.htm} and approximately 60 percent of those eligible for WIC were served. Eligibility requirements include an income below 185% of the federal poverty level. WIC clients must also be determined by a health professional to be at medical or nutritional risk. Participation in WIC can lower Medicaid costs for mothers and newborns. WIC children are better immunized and more likely to have a regular source of health care.

WIC has also been instrumental in the development of the IDEA project, which is a data integration project for state and county agencies. When this system is implemented it will lead to increased efficiency and coordination of public health services.

MIAMI: High-risk pregnant women are served through Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) program, which fosters increased access to health care services for at-risk mothers and infants. This program was initiated in 1986. MIAMI was designed to address barriers to the reduction of infant mortality, provide assurance that mothers and children will be able to access quality maternal and child health services, and reduce the incidence of low birthweight infants, and infants born with chronic illnesses, birth defects, and severe disabilities which result from inadequate prenatal care. MIAMI includes four key components:

- Local care coordination services for high-risk pregnant women

- Public education regarding the importance of early and continuous prenatal care, which leads to healthy pregnancy outcomes
- Fetal, infant, and child mortality reviews (FICMR)
- Medicaid changes which assure access to services that improve the health of pregnant women, mothers, and infants

Through MIAMI the client receives home visits by a public health nurse, a social worker, and a dietician. The program also provides education about the benefits of early prenatal care, and resources to improve access to medical care, in order to increase the likelihood of a successful term pregnancy.

MIAMI targets the 20% of the pregnant population most at risk for negative pregnancy outcomes. As of 1998, there were 31 MIAMI projects in Montana with 4 located on Indian reservations. These MIAMI programs provide annual care coordination for approximately 1,500 high-risk pregnant women.

Home Visiting: "Follow Me" is a specialized home visiting program for children with developmental, biological, or environmental risk factors. Follow Me currently provides home visits for children ages 0-5, in 16 counties. The goal of the program is to enhance child health and development, promote parenting, and ensure early intervention service for identified "at risk" infants and children. The program is designed to follow children to and through systems of intervention for needed services, up until school entry. In 1996, 2,622 children were enrolled in the program. The number of children served increased to over 4,000 children in 1998. Expected outcomes for children participating in the Follow Me program include:

- Up-to-date immunization status
- A reduced incidence of child abuse and neglect
- Periodic developmental screening and assessment
- An identified "medical home" where a child is followed for routine medical care
- Living in families where subsequent children are planned and spaced in at least two year intervals

An outcome-based evaluation plan for the Follow Me home visiting program was prepared in 1998 and is currently being implemented at the State level.

Children and Adolescents

The following table is a list of the enabling programs and resources provided for children and adolescents.

Program	Target Group	Eligibility	Program Description	Provider
Follow Me	At risk children 0-5	At risk for biological, develop., or env. factors	Intensive home visiting and targeted case management program	PH Nurse, Social Worker, Dietician
CHIP	Children 1-18	Below 150% of poverty and Medicaid ineligible	Children's insurance program	Access to professional medical care
Caring Program	Children	Below 150-185% of poverty level	Program that provides health care coverage for children with financial barriers. Funded by donations and matching funds.	Access to professional medical care
MT Children's Trust Fund	Children and parents	Open to submitted proposals	Funds proposals that function to prevent child abuse in communities across the state	Varies by proposal
Montana Promise	MT children	Open to submitted proposals	Provides seed money for projects that support the health and well being of youth in Montana	Varies by proposal

The Follow-Me program was described in the prior section under programs for women and infants.

Montana's Children's Health Insurance Plan (CHIP) is a low-cost, private health insurance plan that provides health insurance coverage to eligible Montana children through age 18 that are not eligible for Medicaid coverage. Financial eligibility is based on a family's adjusted gross income. CHIP is funded by the federal government, ($11.7 million), state government ($2.6 million) and parents who pay an annual enrollment fee and make a co-payment for each visit.

A pilot program for CHIP was authorized by the 1997 Montana Legislature and enrolled approximately 1,000 children. The 1999 Montana Legislature appropriated money to expand CHIP. Approximately 10,000 Montana children are now authorized to receive health care benefits. As of August 1, 2000, 7,034 children have been enrolled with a steady increase of 600-800 children enrolling in CHIP per month. As of June 1, 2000 DPHHS eliminated the annual $15 enrollment fee and the co-payment for American Indian children. Healthy Mothers, Healthy Babies, a recipient of the Robert Wood Johnson "Covering Kids" grant is a contractor working with the State CHIP office to identify and enroll uninsured children in Medicaid and the CHIP insurance plan.

The Caring Program provides funding for health care expenses for children that are not covered by insurance programs. This program is administered though Blue Cross Blue Shield of Montana and is funded through private and public donations.

Two additional programs seek to increase the health and well being of children across the state by funding individual proposals. These programs are the Montana Children's Trust Fund and the Promise programs. The Montana Children's Trust Fund provides grant money for projects that aid in the prevention of child abuse. Funds for this project come from a variety of sources including federal funds, divorce filing fees, and income tax checkbox donations. For 1998-1999, the Fund was able to allocate money to ten very different projects. For example, the Missoula City/County Health Department was funded to support their program that provides education and intensive home visits to parents identified as having cognitive difficulties. Another funded program was developed by the Montana Women's Correctional Center to provide parenting education, intervention, and mentoring for female inmates with children to encourage positive parent-child bonds. Other funded programs focused on issues such as teen parenting, developing partnerships among organizations, and single parenting. All programs funded by the Children's Trust Fund address ways to reduce child abuse and neglect in Montana communities.

Montana's Promise was developed from the Governor's Summit on Youth in the winter of 1997. It's mission is to provide an additional 10,000 Montana youth with access to the five fundamental resources necessary for leading healthy, fulfilling, and productive lives. These resources were identified as a caring adult, safe places, a healthy start, marketable skills, and opportunities to serve. Montana's Promise is funded and supported by businesses and individuals throughout the State. As of January 2000, Promise had given out 25 seed grants. There were 35 communities with Promise endeavors and the program had reached 7,315 youth. Examples of funded programs are the Belgrade program of reward and recognition for young people giving back to their community. A mentoring program in Gallatin County was funded to support the transition of rural 8th graders into the larger Gallatin County High School. In Glasgow a program was funded for adult mentors working with youth on a greenhouse project to grow and sell native plants.

Children with Special Health Care Needs

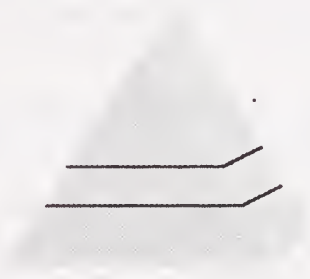
The following table is a list of the enabling programs and resources provided for CSHCN.

Program	Target Group	Eligibility	Program Description	Provider
Follow-up of Abnormal Newborn Screens	CSHCN	None	Follow-up program of abnormal newborn screens, facilitates links to other needed special services	Multiple
Follow Me	Children and families "at risk"	Identified risk factors	A public health nurse home visiting program that identifies delays and connects parents with needed services	Public Health Nurses
CHIP	CSHCN 1-18	Below 150% of poverty level and Medicaid ineligible	Children's health insurance program	Multiple

Women of Childbearing Age

Family planning clinics provide enabling services to women of childbearing age in Montana by providing health education on issues such as sexually transmitted diseases, osteoporosis, and breast and cervical cancer prevention. Family planning clinics collect information on nutrition and lifestyle activities through intake forms and are able to direct clients to community resources for enhancing a healthy lifestyle. Family Planning clinics will be discussed further under Population Based Services.

POPULATION BASED SERVICES



Population Based Services are broad-based programs that aim to increase health screening and prevention of health problems. State concerns related to population based services are:

- Increasing the availability of lead screening for children
- Increasing the number of immunized children
- Identification and surveillance of newborns and infants with congenital birth defects including FAS

- Decreasing the incidence of birth defects through education campaigns
- Increasing oral health among children
- Increasing the awareness of SIDS prevention and identification of cases
- Increasing the number of women screened for breast and cervical cancer
- Decreasing unintentional injuries and death through improved safety awareness
- Decreasing teen pregnancy through education
- Decreasing the rate of adolescent suicide

Pregnant Women and Infants

The following table is a list of the population-based programs and resources available for pregnant women and infants in Montana.

Program	Target Group	Eligibility	Program Description	Provider
Pregnancy Risk Line	Pregnant women	None	Free hotline for pregnant women to call for information	Contract with providers
Well-Baby Screening	Infants	None	Medical professional screening exams to check the infant's development	PH Nurse at public screening clinics
WIC	Women, infants, and children	Percentage of poverty	Provides nutrition education, supplemental food, and referrals to other needed services	WIC staff
Statewide Immunization Efforts	Infants	None	Clinics to provide immunizations	Public health offices
MT's Child and Other Healthy Mothers, Healthy Babies' programs	Mothers and infants	None	Public education on topics such as breastfeeding, safety issues, and parenting; provides resources and link-ups to other services. 800 number for MCH questions.	HMHB staff
All Education Programs (pregnancy, FAS, prenatal, nutrition, shaken baby syndrome, SIDS, child abuse, etc.)	Pregnant women	None	Outreach programs to educate women on various issues	State staff dissemin-ate information

Pregnancy Risk Line: This is a hotline service that is provided through a contract with the University of Utah. Since 1986 the Pregnancy Risk Line (PRL), has enabled women to make a toll-free call with questions about the risks to themselves, fetuses, or breastfed infants associated with exposure to substances in the environment. The telephone service is available between 8:30 AM and 4:30 PM Monday through Friday. A data review for the PRL indicated that during January 1994 to June 1998, 70% of the calls received were from pregnant women, and 30% of the calls were from health care professionals. The Women's Health Section conducted a recent survey of OB/GYN and Family Practice physicians (n=359) to determine the extent of awareness and use of the Pregnancy Risk Line. A summary of results can be found in appendix I.

Well-Baby Screening: Well-Baby screens of the infant population are performed by health professionals across the State of Montana. The Department of Public Health and Human Services strongly promotes well-baby screening. In addition the Follow-Me home visiting program provides outreach to families with financial needs or identified risks in order to increase the number of infants who receive well-baby checks.

Whether or not an individual county spends MCH block grant dollars on well-baby screening is at the discretion of each county. Fiscal management decisions concerning local health departments vary for each county and the counties have the autonomy to spend their funds in the way they choose. Geographical distribution of public health services across the state vary related to county appropriation of funds.

WIC: WIC provides nutrition education and supplemental food. In addition WIC serves as a catalyst to accessing other public health services. The State does not provide direct management of WIC services. However, WIC works closely with other state MCH programs as they often serve the same clients. WIC is funded entirely by the U.S.Department of Agriculture. No MCH block grant funds directly contribute to the program. Every county within the state has at least one WIC clinic, thus providing equality of geographical distribution. WIC is also the lead agency for the lead screening program grant.

Statewide Immunization Efforts: Immunization efforts work much the same way as the well-baby screening from both a local and state perspective. Counties can choose to use MCH block grant funds to provide immunization programs. The state provides a data base system to track immunizations, and provides training and support.

Montana's Child: Montana's Child is project of Healthy Mothers, Healthy Babies (HMHB). Prior to 1996.the program was called "Baby your Baby". The name change reflects the fact that the program now serves children up to age 18. Montana's Child serves as a single point of contact for Montana families to learn more about maternal child health issues and related services. This program

provides education as well as referral to services. A 1-800 number allows individuals to speak directly with a HMHB staffer based in Helena with questions and advice issues related to pregnancy, child health and maternal health. Phone contact can provide referral to local services, disseminate information through follow-up mailings, and answer specific child care questions. The types of calls received and the issues of concern raised by the callers provide a barometer of public health issues in Montana. Appendix C contains a summary of the types of calls received recently. Funding for the Montana Child program is provided through fund raising, grants and matching State medicaid funds.

There are other projects within HMHB with various public/ private funding schemes. These programs include the following: *Covering Kids*, a program to increase children's health insurance coverage through advocating enrollment in State Medicaid and CHIP programs, Injury Prevention programs run by HMHB including; *Montana Safe Kids, Water Safety, and Bike Safety*, *DD PAC*, is a program to promote awareness of children with developmental disabilities and issues of concern in public service announcements, *Folic Acid Public Education*, is a program that collaborates with other agencies to help prevent congenital malformations, *Promoting Action for Teen Health Project,* is a program to promote teen health and teen pregnancy prevention.

HMHB participates in the *Montana Children's Alliance*. The alliance is composed of people who represent various private and government organizations and meets every two years to write the Montana Children's Agenda for each state legislative session. The Children's Alliance was formed in 1987. It will be described further under the infrastructure building section that follows.

Education Programs: The State has established several health education programs. The focus of some is to train trainers on public health issues. For example, MCH block grant funds support the spring meeting of public health nurses in the state, regional public health meetings, public health nurse orientation, and other meetings in which nurses are trained on fetal alcohol syndrome, prenatal care, nutrition, and a variety of other issues. Armed with this knowledge, the nurses are able to educate in the local communities. As part of their contract with the State, the nurses are required to attend either the spring meeting or the annual public health association meeting in Montana.

The Family and Community Health Bureau staff provides educational inservices to the public health nurses, or may contract with some other entity or individual to provide education. Unfortunately, the geographical distribution of educational services varies even though the State does try to provide meetings and workshops in the various regions.

Children and Adolescents

The following table is a list of the population-based programs and resources for children and adolescents.

Program	Target Group	Eligibility	Program Description	Provider
Fluoride Mouth Rinse Program	Children 5-18	None	Fluoride mouth rinse is provided to all children in serviced schools to help prevent tooth decay	Schools where available
Well-Child Screening	Children 1-18	None	Medical professional screening exam to check child's development	Private and PH clinics
WIC	Women, infants, and children	Percentage of poverty	Provides nutrition education, supplemental food, and referrals to other needed services	WIC clinics
Statewide Immunization Efforts	Children 1-21	None	Clinics to provide immunizations	PH clinics
Lead Screening	Children 1-6	None	Blood levels of lead screened in children	WIC clinics and private clinics
Adolescent Suicide Prevention Efforts	Children 10-19	None	Psychological autopsy being developed; will look at prevention to postvention resources in a community	CACH
School Nurse/Screening	Children 5-18	None	Screening for hearing, vision, dental, and scoliosis	School Nurses
Injury Prevention Efforts	Children 1-21	None	Results of FICMR efforts—prevention efforts to reduce unintentional injuries	PSAs
Nutrition Education	Children 5-18	None	School-wide education on the importance of good nutrition	Schools
Substance Abuse Education	Children 5-18	None	School-wide education on substance abuse	Schools, DARE
Abstinence Education	Children 10-19	None	Education program to reduce teen pregnancy and STDs, by advocating abstinence from sexual intercourse	State Abstinence Education Program
Montana Behavior Initiative	Children 5-18	None	Program within certain schools that focus on the reduction of violence within communities	OPI

Fluoride Mouth Rinse Program: The fluoride mouth rinse program is provided to all county schools when requested. It is a free oral health program for students, paid for by MCH block grant dollars. A school nurse or local public health nurse administers the fluoride rinse to students. The State does not directly manage this program. Rather the State's primary role in this program is to dispense the resources, provide advice and make recommendations. Most

schools across the state have the program, but some rural counties are currently not participating.

Well-Child Screening: Well-Child screens are carried out in the same manner that well-baby screens are done as discussed in the section above. The State strongly advocates for the inclusion of well-child checks into the health practices of all Montanans. The Follow-Me program provides outreach to families, which may otherwise not receive this service.

WIC and Statewide Immunization: For a more detailed look at these programs, see the Pregnant Women and Infants section under population-based services.

Lead Screening: The lead screening program is managed by the WIC office. The state DPHHS and WIC collaborate on program management. This program is primarily funded through a grant that was recently received to improve lead screening of children. These funds are used in conjunction with other grants to provide education and information to localities that have a higher incidence of lead exposure—such as Superfund sites and mining towns. Recently Medicaid agreed to reimburse providers at a rate of $3.00 per capillary and venous draw. There is an effort to increase the number of children screened in the state. The lead screening program was available in 39 of the 56 counties in 1999. The director of the program is encouraging more physician involvement to increase the number of children screened in Montana.

Adolescent Suicide Prevention Efforts: The state has recognized the growing problem of adolescent suicide and has been active in attempting to address this concern. The adolescent coordinator for the state, along with the EMS director, have conducted a survey to determine exactly what type of prevention efforts are currently taking place within the state. Appendix F details the findings of this survey. The state is currently looking for grant funding that can help supplement current efforts. The State's goal is to set up suicide prevention education programs throughout the state, but especially for the counties that had a higher suicide rate in the last ten years. These education efforts would not only cover the issue of suicide directly, but underlying issues such as substance abuse, violence, and family dysfunction. A State suicide prevention plan will be finalized at the state Public Health meeting in September 2000.

School Health Screening: School Health Nurses are funded by school districts in Montana. In 1999 there were only 43 school nurses in Montana full or part-time, and one school-based health center. DPHHS sent a survey to the principal of every school in Montana in 2000 to further assess the shortage of school nurses. Since not all schools employ nurses, some districts contract with county public health nurses to provide school screening. Conflicts develop when a public health nurse contracted to provide screening is also expected to see children with acute illness within the schools. The DPHHS is currently working on policies and standards for public health nurses working in schools.

Availability of school nurses is important due to a number of factors. These factors include the rise in the number of children requiring asthma medication at school, children with special needs requiring medical assistance, uninsured children who lack access to medical care, and the high level of children living in poverty. School nurses allow children to be screened for mental and physical health issues and thereby be referred to appropriate health services.

Injury Prevention Efforts: The State EMS director recently received a grant to increase injury prevention efforts. This program is an offshoot of recommendations made by FICMR teams. Seatbelts and adequate child restraints in vehicles are an important concern in the state. There is currently collaboration between the state DPHHS, the governor, the media, and the police departments on this issue.

Nutrition Education: WIC provides nutrition education to all of its clients, but some schools also provide a great deal of nutrition education to school age children. It is not a mandated and therefore there are disparities between schools in this regard. There are no MCH block grant dollars that contribute to nutrition education. It is an issue currently governed by the school district's or county's priorities. There is a need for increased DPHHS collaboration with agencies and organizations to improve education on nutrition issues. Obesity among children has begun to rise in the US and childhood obesity is an identified MCH concern by the Indian Health Services. Childhood obesity leads to increased incidence of diabetes among children.

Substance Abuse Education: Substance abuse education for children and adolescents predominately occurs at the local level via schools, police department programs, and through PSAs . Substance use and abuse is an important concern in Montana and more prevention education is needed. Drug abuse can be closely associated with other issues such as domestic violence, unintentional injuries, and suicide. Collaboration is needed to increase efforts between groups to prevent substance abuse. MCH block grant dollars are not directed towards substance abuse programs.

Abstinence Education: There are two types of abstinence education: abstinence-based, and abstinence-only. Both promote abstinence as a means of birth control. However abstinence-only education does not allow for the discussion of other methods of birth control. Abstinence-only education is funded through a federal grant that was recently received by the State. The Women's Section of the DPHHS manages the administration of funds to the abstinence-only programs along with the family planning services. Schools determine whether or not students receive abstinence-based or abstinence-only education. Abstinence education versus family planning for teens remains a controversial area.

Abstinence education, as defined by the federal MCH Bureau means an educational or motivational program that follows the following criteria:

- Has the exclusive purpose of teaching the social, psychological, and health gains to be realized by abstaining from sexual activity
- Teaches abstinence from sexual activity outside marriage as the expected standard for all school age children
- Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems
- Teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity
- Teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects
- Teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society
- Teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances
- Teaches the importance of self-sufficiency before engaging in sexual activity

Montana Behavior Initiative: This is a program of the Office of Public Instruction (OPI). It focuses on decreasing violence within schools, thus decreasing violence within communities. Education focuses on those students at risk for violent behavior. The state DPHHS does not provide any funds to this program, and does not have input in program management. Not all schools have the program, but it is possible for all to participate in it. To be a part of the program, the faculty and staff of the school must participate in a training workshop that provides them with the skills and knowledge to deal with potentially violent situations. The Montana Behavior Initiative seeks to provide proactive prevention by providing appropriate education to school staff.

Children with Special Health Care Needs

The following table is a list of the population-based programs and resources related to children with special health care needs (CSHCN). There are only two programs listed in this area. Because of the special nature of this population, more programs and resources naturally fall into the direct services level of the MCH pyramid.

Program	Target Group	Eligibility	Program Description	Provider
Newborn Screening	All newborns	None	Universal screening of all newborns for inborn errors of metabolism	Hospitals
Hearing Screening	Newborns	None	Screening for hearing deficiencies	Hospitals

Newborn and Hearing Screening: Administration of the newborn and hearing screening programs was recently moved into the SHS section of the DPHHS. Combining the administration of these programs should lead to improved surveillance and follow-up of children with identified needs. Another goal of combining administration of these programs is to obtain a more accurate count of the number of children in Montana with special health care needs. If a child is screened and determined to need follow-up, SHS will act as a resource in linking children and families with the program that will best meet their needs. Appropriate programs may include Part C/Early Intervention, SHS, or another agency. Direct management of a child's care will go to the most appropriate program, which will collaborate with the child's family and physician.
All newborns are screened for inborn errors of metabolism before they leave the hospital. In addition, approximately 30% of all newborns are screened for hearing problems. There is variation in the distribution of hearing screening services across the state. Small rural hospitals are having more difficulty than the larger hospitals in implementing hearing screening because of the cost of the screening equipment. Hearing screening is not currently mandated but the State recommends it for all newborns.

Newborn screening is funded in part from the MCH block grant, but current funding is proving to be inadequate. The State is surveying other states to access alternatives for funding newborn screening. There is currently no funding for the provision of hearing screening.. A proposal to help purchase equipment from Medicaid savings for hearing screening is being considered.

Women of Childbearing Age

The following table is a list of the population-based programs and resources for women of childbearing age.

Program	Target Group	Eligibility	Program Description	Provider
Family Planning Services	Women 15-44	None	Program that provides education, and FP services to improve reproductive health. Title X funds.	Family Planning clinics
WIC	Women, infants, and children	Percentage of poverty	Program that provides nutrition education, supplemental food, and referrals to other services. Dept. of Agriculture funding.	WIC Clinic
Adult Immunization Program	Women and men	None	Program to provide immunizations and education on disease prevention to adults	PH Clinics
Domestic Violence/Sexual Assault Prevention Programs	Women and families	None	Programs to help prevent domestic violence and sexual assault by providing shelter, education, etc.	Multiple
STD Prevention Efforts	Women 15-44,	None	Programs to help prevent STDs by providing education, etc.	Clinics, PSAs

	and men			
Unintentional Pregnancy Prevention Efforts	Women 15-44	None	Programs to educate and prevent the incidence of unintentional pregnancies	Family Planning clinics
Substance Abuse Education	Women 15-44	None	Programs that provide education and promote activities which reduce substance abuse	Multiple
Other Education Programs	Women 15-44	None	Education programs on issues such as osteoporosis prevention and folic acid use	Multiple

Family Planning Services: Family planning is provided through federal Title X funds, and managed through the Women's Health section of the Family and Community Health Bureau. Family planning frequently collaborates with other programs within the Family and Community Health Bureau due to the fact that they have similar goals of improving the reproductive health of all Montanans. Family planning clinics are not located in every county within the state, but educational services are available throughout the state.

WIC: WIC was previously described in the section above in the pregnant women and infants portion of population-based services.

Adult Immunization Program: Montana does not have good data on the number of adults that need immunizations. Some counties utilize MCH block grant funds to provide immunizations for adult clients, whereas others do not. The Immunization section of the DPHHS provides support to these programs.

Domestic Violence/Sexual Assault Prevention Programs: Appendix G identifies prevention efforts related to domestic violence and sexual assault. Most programs have been initiated by advocacy groups. The state does help fund a hotline with the Montana Coalition Against Domestic and Sexual Violence (MCADSV) that serves the entire state, but otherwise programs are reliant on other funding sources.

STD Prevention Efforts: Education efforts for the prevention of STDs are primarily located within family planning programs. There is also collaboration between private health care providers and State organizations.

Unintentional Pregnancy Prevention Efforts: The majority of education on unintended pregnancy prevention takes place within family planning clinics. Unintended pregnancy has become an increasing problem for women age 15-19 Montana ranks 4th nationwide for the percent of reported legal abortions obtained by teenagers. This is an area where increased MCH block grant dollars may be needed as well as increased collaboration between organizations.

Substance Abuse Education: Substance abuse among adults is of concern especially when realizing how it affects other issues such as domestic violence,

child abuse and neglect and unwanted pregnancy. Education programs for adults are limited in the State and this is an area where increased collaboration and funding could benefit families .

Other Education Programs: Montana has other education programs that relate to issues such as osteoporosis prevention and folic acid use for women of childbearing age. These programs are funded by specific grants. A community can choose to apply for available grant funding to provide education at the local level.

INFRASTRUCTURE BUILDING SERVICES

Infrastructure Building Services provide support for all of the other types of public health services. Included in this category are needs assessments, program development, program evaluation, policy development, standards development, training, research, activities that promote linkages between providers and agencies, and the development of information management systems. Priority needs in this service area include:

- Increase coordination of services with IHS
- Support development of integrated data system to improve the efficiency of data collection and program reporting for local PH providers
- Provide training and support for local needs assessment
- Advocate for the use of tobacco settlement funds into preventative health programs
- Continue to identify emerging needs such as asthma prevalence, obesity and environmental concerns
- Improve program evaluation processes and increase consumer feedback to continually improve the quality of programs.

Pregnant Women and Infants

The table below outlines infrastructure building programs for coordination of services for pregnant women and infants.

Program	Target Group	Eligibility	Program Description	Providers
Follow Me	**Program**	**Target Group**	Public Health Home visiting program. Coordinators provide linkages with providers	PH Nurses
MIAMI	Pregnant women	Risk Factors	Provides links between families, providers of high-risk obstetric care, and pediatricians.	PH Nurses
FICMR	Infants, children	None	Program to review infant and child deaths to coordinate efforts to prevent further deaths	Local and state teams.
MBOMS	Infants	None	Program to develop an integrated data base to improve surveillance and connect community services for CSHCN.	Special Health Services will coordinate program

There are three large hospitals in the state designated "Level III" centers for perinatal care and these facilities have developed linkages with providers in outlying areas for provision of care to high-risk pregnant women. There are three neonatologists and two perinatologists in the state. These professioals are actively involved in outreach and one perinatologist has a fixed wing airplane to fly to an area of need. MIAMI and Follow-Me coordinators also have strong linkages with the providers of high-risk obstetric care, dentists and pediatricians in their respective health care service delivery areas.

It is the high-risk pregnant women who lack early access to prenatal care who continue to need improved coordination of services. Home visiting of pregnant women does not exist in all counties in the state. Prenatal and Lamaze classes, while often available, may not be affordable or accessible to all women in Montana. It is estimated by the Family and Community Health Bureau that the MIAMI program services are available to approximately 86% of high risk pregnant women in Montana. There is a need for public health nurses and home visiting in all counties. Currently all counties do not have MIAMI or Follow-Me funding. There are 31 MIAMI projects with four on reservations, and 16 Follow-Me projects. Some rural areas lack professionals who would make up the targeted case management team to provide comprehensive services through

MIAMI or Follow-me. There are shortages of registered dieticians, social workers, and BSNs in parts of the state.

The MIAMI projects on Indian reservations have each developed unique models that work within their respective communities. One program works with Head Start mothers to promote healthy parenting throughout pregnancy and beyond. Another project provides transportation to prenatal care 40 miles away. Coordination between health care providers on and off the reservation is required. A major concern is the access to prenatal care by American Indian women living off reservations.

Urban Indian health care centers and migrant health care centers do not reach state-wide to provide direct health care or home visiting services to all American Indians or migrants who need care. Consultation from the Region VIII Minority Health Consultant has resulted in recommendations to develop more culturally competent systems of care through improved communication between the state and tribes. A small OMH grant was awarded to the state to facilitate communication between the state and tribes. Funding for a State Minority Health Coordinator has been requested by the Family and Community Health Bureau to address the need for improved communication and coordination of services for minorities.

Fetal Infant and Child Mortality Review (FICMR), teams have been formed in the State to improve preventative efforts and reduce deaths related to the known causes. A protocol manual was developed in 1997 and was distributed to all the MIAMI communities later that year. There are currently 16 FICMR teams across the state. Three FICMR teams have collaboration between tribes and the county government. There was an identified need to diversify the State FICMR team and include representation from Indian Child Welfare and tribal legal and social services. These team members are being recruited in the year 2000.

Montana Birth Outcome Monitoring System (MBOMS) is funded through assistance from CDC. Efforts will focus on bringing varied data sources together in a central location. Data will be utilized for surveillance, policy development, and service planning.

Children and Adolescents

The following table is a list of the infrastructure building programs and resources provided for children and adolescents.

Program	Target Group	Program Description	Providers
FICMR	Statewide	Program to review infant and child deaths and provide recommendations to prevent future incidents	Local teams
MBOMS	Statewide		
Healthy Childcare Montana	Day Care Center Staff	Provides training of public health nurses to act as health consultants for day care providers	PH nurses
Montana Children's Alliance	Legislators	Promotes well being of children by identifying and educating Montanans about the services considered to be vital to children. Provides recommendations to the state legislature on children's issues.	Alliance of non-profit and gov. agencies
Family and Community Health Advisory Council	State Government	Advises the State Family and Community Health Bureau on matters impacting the health and well being of women, children and CSHCN	Appointed members who represent of range stakeholders
Family and Community Health Bureau	Local Health Departments	Develops standards of care, provides data analysis, needs assessment, training, program evaluation and planning for various programs for children and adolescents. Distributes MCH Block Grant monies to counties via contracts with county public health offices	State staff

FICMR was described earlier and is a statewide system to review fetal, infant, and child deaths to increase understanding of the causes of death and prevent further deaths.

Quality childcare is not affordable for many low-income families and many childcare facilities are of poor to mediocre quality and staffed by untrained workers. The Healthy Child Care Montana program promotes efforts to increase the quality of childcare by providing consultation.

Montana Children's Alliance was initiated in 1987 and develops a "Children's Agenda" every two years which specifies recommendations to the state legislature concerning the needs of children in the State. The purpose of the alliance is to promote the well-being of children by identifying needs and providing education about the services considered vital to Montana's children and families. Members include representative from State agencies, county agencies, professional organizations, non-profit organizations, and health care providers.

The Family and Community Health Advisory Council was formed in 1999 to assist in the interpretation of current national, regional, state and local information relating to the health of mothers and children in Montana. The mission of the council is to assist the State in identifying problems relating to the

delivery of services, access to services, and quality of services available to mothers and children in Montana. The council acts as advocates for the services provided by the Bureau and makes recommendations to improve services to families and children in Montana.

State maternal child health services are administered within the Family and Community Health Bureau (FCHB) of the Montana DPHHS. There are four service sections in the FCHB which include: Child, Adolescent and Community Health (CACH), Special Health Services (SHS), WIC/Nutrition, and Women's Health. There is also an administrative unit, which is responsible for the Maternal Child Health Block Grant and management of contracts. The Bureau conducts statewide MetNet conferences for county public health personnel each spring and organizes regional meetings with counties during the summer and fall. Public input is requested at regional meetings through the addition of focus groups that began in 1998. While public participation has been limited it is hoped that it will increase as more people become aware of this forum.

The Family and community Health Bureau has an approximate budget of $17.2 million which includes Title V, WIC, Title X, Preventative Health Block Grant, CDC, CISS, SSDI and state general funds. Bureau staff continually work to create responsive and dynamic programs that adhere to funding source requirements and the needs of Montanans. Approximately 88 % of the total Bureau budget is expended at the local level. The Bureau works closely with other agencies to coordinate services. This past year they have worked with CHIP and Medicaid to promote access to improved health and dental services for children. Bureau staff participate on the "Joint Committee for Healthy Kids" to address health needs in the schools. Staff members work with programs such as Mothers Against Drunk Drivers (MADD), on FAS/FAE prevention, and are involved in coordinating efforts with other agencies to prevent substance abuse, suicide and unintentional injury. The State medical director works closely with AAP. ACOG, and AAFP to coordinate efforts with private health care providers.

Some of the activities initiated recently at the Family and Community Health Bureau include strategic planning for the development of a state suicide prevention plan, a state-wide dental summit, development of strategies to improve dental care access, surveys of schools and day cares to access the prevalence of asthma in Montana's children, and a survey of school health programs to assess the need for more school nurse programs.

Each section of the Bureau is continually involved in assessment of programs' effectiveness through data analysis of programs and through summarizing feedback from the local level provided by public health nurses on annual pre-contract surveys. Continuous quality improvement of programs is conducted by public health nurses, state program directors, and through participant surveys at the local level. On the 1999 pre-contract survey it was found that 24 counties

have not begun to include customer satisfaction surveys as was requested as a contract requirement. This is an area where improvement can be made.

Montana does not currently receive Title IV grants for comprehensive HIV care to pediatric, adolescent and women with HIV. As of August 1999 there were only four pediatric AIDS cases in the state reported since 1985. Montana currently has only Ryan White Title II and Title III funded programs for HIV/AIDS. The DPHHS Communicable Disease Prevention and Control Bureau STD/HIV Section administer Title II funds. Title II funded programs in Montana include AIDS Drug Assistance Program (ADAP), Health Insurance Continuation Program (ICP), and HIV Care Consortia. The Deering Community Health Clinic in Billings administers the Title III Program. Title III provides grants to public and private non-profit clinics for early intervention services for individuals seeking HIV counseling.

Children with Special Health Care Needs

The following table is a list of the infrastructure building programs and resources provided for CSHCN.

Program	Program Description	Provider
Regional Clinic Coordination	Plan to regionalize special health care clinics and enhance efficiency of care	Special Health Services
MT Birth Outcomes Monitoring System	Program that tracks targeted birth outcomes, provides surveillance of newborns with targeted outcomes and promotes coordination among providers of services to children with congenital birth defects.	SHS section of DPHHS with CDC funding

Regional Clinics: Special Health Services (SHS) is the section under the Family and Community Health Bureau, which administers funding for CSHCN programs under MCH Block Grant funding. The SHS section in the past been involved primarily in the provision of direct care services for CSHCN however, the section has began a transition towards providing more coordination and infrastructure building services over the past five years. Special Health Services contracts with four regional coordinators in the state to set up three types of clinics for children that are held twice a year. These clinics are Cleft Palate Clinics, Metabolic Disorder Clinics, and the newest type of clinic is a Neural Tube Defect Clinic, which began in January 2000. The state provides training for the regional coordinators on their role of coordinating care within their communities. SHS also began developing a data base system that will track children attending clinics and assist regional coordinators in clinic management. This data base system is being tested in FY 2000.

In an effort to increase the infrastructure at the state level, the SHS division is developing standards of care for regional clinics to improve the quality of care Standards for the metabolic clinic were drafted this year. Planning has begun for development of standards for the cleft palate clinics and neural tube clinics. Special Health Services plans to use chart review to monitor the quality of care once standards are in place and all direct care is coordinated at the local level.

Montana Birth Outcomes Monitoring: MBOMS is a project under the SHS section to improve tracking and follow-up for infants with birth defects. The CDC assists with funding for this project to improve surveillance and coordination of services for children with special health needs in the state.

Collaboration of Services: Services for children with special health care needs in Montana may be provided through several agencies and providers. Collaboration and coordination of services is an important component of infrastructure building. Other agencies that may be involved include the federal PartC/Early Intervention program, SSI, and community-based services. The following section will describe various related agencies and how these agencies collaborate with each other and with local providers of health care.

Part C/Early Intervention: This is a federally funded program with the mission of assuring that all Montana infants and toddlers with disabilities, and their families have the right to comprehensive, and appropriate intervention services. These services should recognize the family as the lead members of the team, and be responsive to the family's needs and dreams for their child. A goal of the Part C program is to enable families to become effective lifelong advocates for their children who have developmental disabilities or delays. The following services are available to children who are eligible for assistance through the Infant and Toddler Program:

- Early identification, screening and assessment (including medical services for diagnostic evaluation purposes)
- Special instruction
- Parent and family education, training and counseling services
- Speech pathology and audiology services
- Physical therapy and occupational therapy
- Psychological services
- Support coordination and social work services
- Health services (necessary for the child to benefit from early intervention services) and nursing services
- Nutrition services
- Vision services
- Assistive technology devices and services
- Transportation and related costs

The Developmental Disabilities Program, of the DPHHS administers the PartC/Early Intervention program. There are currently seven regionally–based Part C agencies across the state, to provide services to families. The federal government mandates that all children that would be considered eligible for this program are included in the program; therefore, there are no income requirements for these services. Eligibility for the program is determined by the child having:

- An established condition which is very likely to result in a developmental delay—even if the delay does not currently exist, and
- A significant delay of 50% in one developmental area or 25% in two or more of the following areas:
    - Communication development
    - Physical development, including vision or hearing
    - Social or emotional development
    - Adaptive development
    - Cognitive development

The majority of the Part C/Early Intervention program funding provides services for children from birth to age three, and then if needed, continues to cover appropriate services. Part C usually serves as the link between families and schools, by helping with the transition into school-based services, such as special education.

Part C and SHS Collaboration: Part C and SHS work together in several ways. The following is a list of ways in which the two agencies combine efforts.

- Provide mutual referrals across agencies (SHS, Follow Me, and Part C) for children/families who may need, or be eligible for services provided by the different groups
- Provide a joint Individualized Family Service Plan (IFSP) and Nursing Care Plan (NCP)—which becomes one document to guide services to the child/family, with roles and responsibilities defined
- Routine discussion and identification at IFSP meetings about the child's/family's need for medical services which might be provided by public health nurses
- Emphasis in discussions with families on the concept that children need a medical home (usually a primary care physician, with the assistance of public health staff) where all of their medical service needs can be tracked and met
- Mutual invitations to training events of interest to both Family Support Specialists (Part C) and Public Health Nurses (SHS)
- Telephone, e-mail, or on-site technical assistance/training at the request of either public health or Part C agencies or staff
- Ongoing (negotiated every three years) formal interagency agreement on coordination of services and responsibilities of each state agency involved in early intervention services, including the Health Policy and Services Division, SHS, Part C, and the Office of Public Instruction

- The director of SHS is a member of the Part C advisory council.

SHS and Collaboration with State agencies and Community Systems: Staff from SHS formally meet each year with state SSI staff. Informally, there is ongoing communication between SHS and SSI divisions throughout the year regarding funding and coordination of care.

In 1999 a Special Health Services Advisory Council was formed to improve collaboration, and access input from parents, pediatricians, public health nurses, Indian Health Services, Part C, dental providers and others with a related interest. This council is a subcommittee of the Family and Community Health Bureau Advisory Council. The SHS Advisory Council will meet every 6 months. The SHS section coordinates efforts with Montana Healthy Mothers Healthy Babies and the state March of Dimes to promote folic acid education throughout the state. Related to providers, there is a strong relationship between SHS and St. Vincent's Hospital in Billings, and Community Hospital in Missoula where outreach clinics are held yearly to evaluate children.

Special Health Services has provided training for county public health nurses in the state on home visiting for CSHCN. The SHS section also funds public health nurses to provide home visiting services. Special Health Services assist parents in obtaining evaluations or testing to determine a diagnosis for a child when financial aid is required and encourages coordination of care through a local pediatrician. They have recently made a request of the training center of the American Association of Pediatricians to provide training for pediatricians in Montana on the definition and use of a "medical home". Medical Home is defined as a primary physician that coordinates a child's care.

All Population Groups

The following table is a list of the infrastructure building programs and resources provided for all the population groups.

Program	Target Group	Eligibility	Program Mission	Funding Sources
Staff Training and Education	Public Health Staff	Staff member	Provides staff education and training to better enable staff to provide quality public health services.	State
IDEA Project	All	None	Enhance integration and efficiency of the management of public health data across the state.	State
Healthy Communities	All	Coalitions	Encourages collaboration among stakeholders and empowers communities to envision and plan for a healthy community through efforts of local coalitions.	State DPHHS and local fund raising

Community Incentive Program (CIP)	All	RFP or MOA	Goal is to develop a comprehensive and coordinated risk –focused prevention delivery system. To build capacity and infrastructure within communities.	Federal State incentive grant
Interagency Coordinating Council	All	RFP	Goal to develop a comprehensive and coordinated prevention delivery system in the state designed to strengthen health, wellbeing and safety of children, families and communities.	Federal Vista grant, ICC member agencies support PRC
Integrated Funding Project	All	Pilot	Improves PH management efficiency by integrating the allocation of funds for multiple state programs to the local level.	
Turning Point Initiative	All	None	Community improvement project to enable communities to create a healthy environment	Turning Point Initiative Grant RWJ Foundation

IDEA Project: The state has been working to develop an integrated public health data system that would increase the efficiency of data gathering and improve collaboration between counties and state public health agencies. A contract was given to Seaquest to develop this system initially but they have defaulted on the contract. As of April, 2000, preparations have begun to convert to an Oracle design. Pilot testing of data conversion is scheduled to begin in August of 2000. Pilot test sites are scheduled to begin in Missoula, Butte, and Shelby by the end of 2000.

Healthy Communities: This program is a State-facilitated program to encourage collaboration among stakeholders in the health of Montana's communities. The mission is to empower communities to create their own vision of a healthier community, determine community needs and assets, and develop strategies to achieve their vision. The State level coalition is funded by DPHHS. Local coalitions are responsible for their own funding with some State assistance with allocation. There is a national Healthier Communities coalition that sponsors teleconferences and other national conferences. Montana is one of 29 states participating. Training is provided to communities through METNETs. There are 23 local level coalitions.

Community Incentive Program: This program's mission is to develop a comprehensive and coordinated statewide risk-focused prevention delivery system designed to strengthen the healthy development, well-being and safety of Montana's children, families, individuals and communities. Funding is provided through a federal and State incentive grant. After 3 years the program is required to leverage other funds to continue. Of the grant money received, 85% goes to local communities. Communities decide how funds will be received and

distributed. Key players besides the communities include the Interagency Coordinating Council, SAMSHA- Substance Abuse and Mental Health Services Administration, CAPT- Center for the Application of Prevention Technology and CSAP-Center for Substance Abuse Prevention. The target group is local coalitions that wish to access funds to develop an infrastructure to prevent teen ATOD use.

Interagency Coordinating Council: The mission of this council is to develop policies and practices within State government that will elevate the importance of prevention. The goal is to develop a comprehensive and coordinated prevention delivery system designed to strengthen the healthy and wellbeing of Montanans. Funding comes from a federal VISTA grant to the Prevention Resource Center (PRC). ICC member agencies contribute $5,000 each to support the operations of the PRC. The ICC funded a 3-year demonstration project in 1996. The PRC's VISTA project has placed 19 VISTAs in 12 communities. Training is provided quarterly to train VISTAs in prevention principles and best practices which includes coalition building, volunteer training, and other topics for building a sound prevention infrastructure. A website has been established for county trend data on 42 social indicators associated with prevention. ICC members include: the Attorney General, the Superintendent of Public Schools, Directors from Labor and Industry, Public Health and Correction; Chair of the Montana Trust Fund, the State Coordinator of Indian Affairs and two other persons appointed by the Governor.

Integrated Funding Project: Currently there are over 12 categories of State public health funds for local health departments. Each category has it's own specific reporting requirements. The goal of the Integrated Funding Project is to consolidate funds allocated to counties and simplify reporting requirements. This project is scheduled to begin in four pilot sites in July, 2001.

Turning Point: The mission of Turning Point to increase the public health system's ability to assess, monitor and respond to the changing health-related needs of Montana communities. A goal is to improve collaboration among the government, communities, organizations, education, labor, and business. Turning Point is funded at the state level by a Robert Wood Johnson grant and DPHHS in-kind. At the local level funding is received from the W.K. Kellogg Foundation. The Public Health Improvement Task Force is a key player in Turning Point. This task force consists of representatives from local health departments, managed care, cooperative extension, university faculty, hospitals, local government, public health association, DPHHS, Dept. of Environmental Quality, Indian Health Service, and the State Legislature. Technical support is provided through the national Turning Point offices at the University of Washington and the National Association of City and County Health Officials.

There are four local Turning Point sites: Gallatin Health Alliance, Cornerstone Project which includes Lake, Flathead, and Sanders counties, Sheridan county,

and the Fort Peck Health Coalition. Each site develops their own public health improvement activities using local ideas and solutions.

SUMMARY OF MONTANA PRIORITY MCH NEEDS:

- Increase access to health care for children (CHIP and School Health Programs)
- Decrease unintended pregnancy
- Increase dental care access for children
- Increase prevention programs (substance abuse, tobacco use, suicide prevention, teen pregnancy prevention, fire arm safety, non-violent conflict resolution)
- Decrease disparities between the health of American Indians and all Montanans (infant mortality, rates of cervical cancer, and diabetes)
- Increase the efficiency of reporting data and the integration of public health data . Increase input from epidemiological analysis
- Decrease the risk of poor health, developmental delays, and child abuse through support and expansion of public health programs that provide outreach to parents and children "at risk" (MIAMI, Follow-Me and parenting education programs)
- Increase access to mental health services and suicide prevention programs
- Increase the training and support of public health nurses

Glossary

AAFP American Association of Family Practitioners
AAP American Association of Pediatricians
ACOG American College of Obstetricians and Gynecologists
ADAP Aids Drug Assistance Program
BRFSS Behavior Risk Factor Surveillance System
CACH Child Adolescent and Community Health
CDC Centers for Disease Control
CHIP Children's Health Insurance Program
CISS Community Integrated Service Systems
CSHCN Children with Special Health Care Needs
DEM Direct Entry Midwives
DEQ Department of Environmental Quality
DPHHS Department of Public Health and Human Services
EMS Emergency Medical Services
EPA Environmental Protection Agency
EPSDT Early Periodic Screening, Diagnosis and Treatment
FAIM Families Achieving Independence in Montana
FAS Fetal Alcohol Syndrome
FCHB Family and Community Health Bureau
FICMR Fetal Infant and Child Mortality Review
HMHB Healthy Mothers, Healthy Babies
ICC Interagency Coordinating Council
HICP Health Insurance Continuation Program
IDEA Integrated Data for Evaluation and Assessment
IFSP Individualized Family Service Program
IHS Indian Health Services
LBW Low Birth Weight
MBOMS Montana Birth Outcomes Monitoring System
MCADSV Montana Coalition Against Domestic and Sexual Violence
MCH Maternal and Child Health
MDVBIP Montana Domestic Violence Batterer's Intervention Program
MIAMI Montana Initiative for the Abatement of Mortality
NCP Nursing Care Plan
OB/GYN Obstetrician/Gynecologist
OBRA Omnibus Budget Reconciliation Act
OPI Office of Public Instruction
PH Public Health
PRC Prevention Resource Center
PSA Public Service Announcement
RFP Request for Proposal
SHS Special Health Services
SIDS Sudden Infant Death Syndrome
SSDI Statewide Systems Development Initiative

SSI Supplemental Security Income
STD Sexually Transmitted Disease
TANF Temporary Assistance for Needy Families
VLBW Very Low Birth Weight
WIC Women Infants and Children Program
YRBS Youth Risk Behavior Survey

Appendices

A MCH Performance Measures

B Pre-contract Survey Results

C Analysis of Calls to Healthy Mothers, Healthy Babies, 1998

D Montana Council for Maternal Child Health Stakeholder Survey

E Survey of Montana Dentists, Healthy Mothers, Healthy Babies

F Survey on Adolescent Suicide Prevention, Intervention, and Postvention

G Domestic Violence Needs Assessment

H Maps

I Pregnancy Risk Line Survey

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Special Health Services, 15, 26, 55-59
Substance Abuse, 24, 28, 47, 50, 62
TANF, 34
Teen Pregnancy, 22
Turning Point, 60-61
Uninsured Children, 19
Unintentional Injury, 17
Violent Crime, 24
WIC, 2, 16, 21, 37, 42, 43, 46, 55
Women of Childbearing Age, 27, 33, 41, 49-51

APPENDIX A

NATIONAL MCH PERFORMANCE MEASURES

	Performance Measure	Pyramid Level of Service			
1	The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	DHC	ES	PBS	IB
		X			
2	The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X			
3	The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical home"		X		
4	Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X	
5	Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hemophilus Influenza, Hepatitis B.			X	
6	The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X	
7	Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X	
8	The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X	
9	Percentage of mothers who breast-feed their infants at hospital discharge.			X	
10	Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X	
11	Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X
12	Percent of children without health insurance.			X	
13	Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.				X
14	The degree to which the State assures family participation in program and policy activities in the State CSHCN program.				X
15	The rate (per 100,000) of suicide deaths among youths aged 15-19.			X	
16	Percent of very low birth weight live births.				X
17	Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X
18	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X

DHC = Direct health care
ES = Enabling services
PBS = Population based services
IB = Infrastructure building

MONTANA STATE PERFORMANCE MEASURES

	Performance Measure	Pyramid Level of Service			
		DHC	ES	PBS	IB
1	Percent of unintended pregnancy.	X			
2	Percent of women reporting alcohol use in pregnancy				X
3	Quality standards for the health care of the MCH population have been established by state staff and their local/community partners.				X
4	Percent of infants who are breastfed at six months.		X		
5	Percent of counties establishing fetal infant child mortality review committees.				X
6	Percent of facilities using standardized domestic violence screening tool as part of care assessment and planning.				X
7	Percent of two year old children screened for lead.			X	
8	Percent of Medicaid eligible children who receive dental services as part of their comprehensive services.				X
9	Percent of pregnant women who report cigarette smoking.				X
10	Rate of firearm deaths among youth aged 5-19.				X

DHC = Direct health care
ES = Enabling services
PBS = Population based services
IB = Infrastructure building

October 8, 1998

APPENDIX B

Needs Assessment - Montana County Public Health Departments

In Montana, the local health departments serve as a major source of information regarding the status of the health of mothers and children. The state maintains a close relationship with the counties and routinely gathers data from them throughout the year. Much data is gathered in response to routine reporting mechanisms and surveys; however, anectodal information, solicited or unsolicited, is also gathered and utilized. Efforts to help counties standardize their data collection systems are ongoing and will be greatly enhanced by the implementation of the public health data system.

PRE CONTRACT SURVEY 1999

In 1999, prior to issuing MCH Block Grant Contracts to local health departments, the Family and Community Health Bureau conducted a survey to assess MCH issues at the county level. All fifty six counties received the survey; ***** responded.

In answering the question, "List in order of importance, the major (most pressing) MCH needs in your county, the following information was collected:

35 counties listed infrastructure/community health needs as the most important need. Included in this category were under or uninsured mothers and children for health and dental services. Inadequate staffing of local health departments as well as lack of primary care providers were listed as the second greatest need. Other topics included the need to increase public awareness of public health resources, inadequate day care resources, lack of coordination of local health service delivery - primarily mental health services, nutrition issues, lead screening needs and help with conducting needs assessments.

27 counties listed issues surrounding pregnancy as needs such as the assurance of early prenatal care, prevention of fetal mortality by early identification and close follow up of high risk pregnancy, prevention of risk behaviors during pregnancy, post partum issues, need for increased WIC services and need for child birth education classes.

26 counties listed violence and associated issues as the next greatest need. Included in responses in this category were domestic violence, substance abuse and associated violence, teen violence, suicide, neglect and racial tension.

22 counties listed immunization as a continuing need including the ability to provide appropriate immunizations and the ability to assess and track immunization status, particularly across county lines.

Women's health (family planning services, unintended pregnancy prevention, reproductive health through menopause, repeated births to "dysfunctional" moms, birth spacing, STDs in women), Adolescent issues (sexual behaviors, teen pregnancy, risk taking behaviors, teen health education) and Children's issues (prevention of mortality, well child screening, dental access)

were ranked next by 19 counties.

13 counties listed family life problems including the need for parenting skills, education and support and the issues plaguing "dysfunctional families" (lack of paternal involvement, abuse)

Issues related to socioeconomic status were listed by 12 counties and included all problems related to poverty, lack of education, unemployment, lack of reliable and accessible and affordable transportation, lack of access to health insurance for "in between" families.

Surprisingly, only 8 counties listed infant issues as a priority need. Those that did mentioned breastfeeding, prevention of LBW, and home visiting services to at risk newborns.

Finally, counties included communicable disease tracking and STD/HIV prevention, expanded school health services including screenings, lice, teaching and other miscellaneous topics such as an analysis of the impact of welfare reform, billing and reimbursement problems and the need for "more money". The need for increased WIC services was mentioned several times.

In Montana, counties are also required to submit a plan in order to receive MCH block grant funding. The plan requires identification of areas of highest need. It is interesting to note that there is very little correlation between the needs listed on the precontract surveys and the MCH block grant plans. One explanation might be that on the MCH county plans, needs are linked to plans while the precontract survey is a more global assessment of need.

Plans for 2000 - 2001 listed teen pregnancy, STD rates, risk behaviors as major issues, followed by children in poverty and lack of insurance, family support issues, lack of housing.

PRIORITY MCH ISSUES

PUBLIC INPUT (HMHB 800 Information Line)

Top five issues in order with #1 being mentioned most frequently

July 1, 1999 through February 15, 2000

HELP WITH CHILDREN

1. Paying for health care
2. Paying for insurance coverage
3. Help with parenting skills
4. Dental care
5. Finding a health care provider

Other issues ranking close to #5: recent family changes, help with special health needs, paying for food

HELP WITH A PREGNANCY

1. Paying for pregnancy visits or delivery
2. Paying for healthy foods
3. Selecting healthy foods
4. Finding housing
5. Personal safety

Other issues ranking close to #5: transportation, not receiving prenatal care

July 1, 1998 through June 30, 1999

HELP WITH CHILDREN

1. Paying for insurance

2. Paying for health care

3. Dental care

4. Finding a health care provider

5. Help with parenting skills

Other significant issues: paying for food and nutritious foods, housing and finding child care provider.

HELP WITH A PREGNANCY

1. Not receiving prenatal care (20%)

2. Paying for prenatal care

3. Selecting healthy foods

4. Paying for healthy foods

5. Help with housing

PARTNER SURVEY

Montana Council for Maternal and Child Health 2001 Scoping Survey

Top five issues in order with #1 receiving the highest rank

1. Children's Health Insurance: Continuing outreach efforts
   Broadening the program to include up to 200% FPL

2. Local Data re: Children's Health: Critical for legislative support
   Include environmental hazards

3. Dental Access: Shortages of dentists and hygienists
   Reimbursement rates

4. Tobacco Use Prevention: Dedicating settlement money to health care issues
   Establishing a settlement trust
   More focus on prevention of smoking in pregnant women

5. Mental Health: Lack of prioritized spending and programs

Access for children to appropriate levels of care

Other issues ranking close to #5: Foster care, welfare reform - FAIM II, child care

MCH PARTNER SURVEY FEBRUARY 2000

Top five issues listed in rank order

1. Nutrition
2. Preventive medical/dental care
3. Parents with addictions
4. Parenting education
5. Home visiting programs

FCHB PRE-CONTRACT SURVEY OF PUBLIC HEALTH DEPARTMENTS

2000 SURVEY RESULTS

Top five issues in order with #1 being mentioned most frequently

1. Substance abuse
2. Family support, education, parenting issues
3. Teen/unintended pregnancy
4. Domestic violence, abuse, neglect
5. Lack of OB services, prenatal care

1999 survey results

Top five issues in order with #1 being mentioned most frequently

1. Infrastructure issues...under or uninsured mothers and children for health and dental care,

inadequate staffing of health departments, lack of primary care providers

2. Pregnancy issues...lack of early prenatal care, need to follow up high risk pregnancies, prevention of risk behaviors during pregnancy, need for increased WIC services

3. Domestic violence, substance abuse, teen violence, suicide, neglect, racial tension

4. Continuing ability to provide immunizations and ability to track immunization status across county lines

5. Women's health issues...unintended pregnancy, repeated births to "dysfunctional moms", STDs in women, adolescent sexual behaviors

APPENDIX C

Healthy Mothers, Healthy Babies--Referring Counties

County	# Times Referred	% of referrals
Beaverhead	0	0.0%
Big Horn	5	1.3%
Blaine	2	0.5%
Broadwater	1	0.3%
Carbon	6	1.5%
Cascade	54	13.7%
Choteau	0	0.0%
Custer	2	0.5%
Daniels	0	0.0%
Dawson	2	0.5%
Deer Lodge	3	0.8%
Fallon	1	0.3%
Fergus	8	2.0%
Flathead	33	8.4%
Gallatin	28	7.1%
Garfield	0	0.0%
Glacier	4	1.0%
Granite	1	0.3%
Hill	12	3.0%
Jefferson	2	0.5%
Lake	10	2.5%
Lewis and Clark	19	4.8%
Liberty	0	0.0%
Lincoln	20	5.1%
Madison	0	0.0%
McCone	1	0.3%
Meagher	2	0.5%
Mineral	3	0.8%
Missoula	39	9.9%
Musselshell	4	1.0%
Park	8	2.0%
Petroleum	0	0.0%
Phillips	2	0.5%
Pondera	2	0.5%
Powder River	0	0.0%
Powell	0	0.0%
Prairie	0	0.0%
Ravalli	25	6.3%
Richland	6	1.5%
Roosevelt	7	1.8%
Rosebud	1	0.3%
Sanders	2	0.5%
Sheridan	1	0.3%
Silver Bow	14	3.5%
Stillwater	1	0.3%
Sweet Grass	0	0.0%
Teton	3	0.8%
Toole	5	1.3%
Valley	3	0.8%
Wheatland	0	0.0%
Wibaux	0	0.0%
Yellowstone	53	13.4%
TOTAL:	395	100.0%

Healthy Mothers, Healthy Babies--Pregnancy

Help with:	# needing help	% of calls	Special %
Pregnancy	**142**		
Not receiving prenatal care	25	6.1%	
Finding a health care provider	31	7.6%	
Paying for pregnancy visits	63	15.4%	
Finding child care services	29	7.1%	
Selecting healthy foods	49	12.0%	
Paying for healthy foods	52	12.7%	
Housing	46	11.2%	
Transportation	27	6.6%	
Safety:	41	10.0%	100.0%
Personal safety	1	0.2%	2.4%
Home safety	12	2.9%	29.3%
Guns and safety	3	0.7%	7.3%
Water safety	2	0.5%	4.9%
General safety	23	5.6%	56.1%
Alcohol/Drug problems	2	0.5%	
Quitting smoking	25	6.1%	
Someone in household to quit smoking	8	2.0%	
Other:	10	2.4%	
Mood swings	1	0.2%	
Dealing w/anger	1	0.2%	
Breastfeeding	2	0.5%	
Job loss	1	0.2%	
Lamaze classes	1	0.2%	
Increasing medical bills	1	0.2%	
Needing baby supplies	2	0.5%	
High-risk pregnancy--age	1	0.2%	
No electricity	1	0.2%	
Total:	409	100%	

Healthy Mothers, Healthy Babies–Children

Help with:	**# needing help**	**% of calls**	**Special %**
Children	**308**		
Finding a health care provider	74	5.3%	
Paying for health care	163	11.6%	
Paying for insurance coverage	196	14.0%	
Immunization	14	1.0%	
Dental care	130	9.3%	
Special health needs:	118	8.4%	100.0%
Allergies	1	0.1%	0.8%
Brain injuries	2	0.1%	1.7%
Diabetes	1	0.1%	0.8%
Vision	8	0.6%	6.8%
Hepatitus C	1	0.1%	0.8%
Hearing	10	0.7%	8.5%
Ear problems	2	0.1%	1.7%
Asthma	19	1.4%	16.1%
Kidney infections	2	0.1%	1.7%
Speech problems	8	0.6%	6.8%
Appreria (?)	1	0.1%	0.8%
Hole in heart	1	0.1%	0.8%
ADD	10	0.7%	8.5%
ADHD	15	1.1%	12.7%
Physical disability	1	0.1%	0.8%
No muscle development	2	0.1%	1.7%
Blood disorder	1	0.1%	0.8%
Mental health	11	0.8%	9.3%
Apnea monitor	2	0.1%	1.7%
Mom: Fibromylagia	1	0.1%	0.8%
Immune system disorder	1	0.1%	0.8%
Epilepsy	4	0.3%	3.4%
Autism	2	0.1%	1.7%
Exema	2	0.1%	1.7%
Scoliosis	1	0.1%	0.8%
Heart problems	2	0.1%	1.7%
Insurance	4	0.3%	3.4%
Chronic bronchitis	1	0.1%	0.8%
Kidney removed	1	0.1%	0.8%
CNS disorder	1	0.1%	0.8%
Dealing w/change: Divorce	27	1.9%	
Dealing w/change: Death	3	0.2%	
Dealing w/change: Moving	39	2.8%	
Dealing w/change: Other:	43	3.1%	
General	34	2.4%	
Umemployment	5	0.4%	
Grandma with cancer	1	0.1%	
Custody battles	2	0.1%	
Job change	1	0.1%	
Finding child care	53	3.8%	
Selecting healthy food	59	4.2%	

Paying for food	82	5.8%	
Eating habits or nutrition	78	5.6%	
Housing	54	3.8%	
Transportation to doctor	23	1.6%	
Parenting skills	122	8.7%	
School issues:	17	1.2%	100.0%
Learning disabilities	6	0.4%	35.3%
No school	1	0.1%	5.9%
Preschool planning	1	0.1%	5.9%
Behavioral problems	4	0.3%	23.5%
Teacher conflicts	1	0.1%	5.9%
Can't help with homework	1	0.1%	5.9%
Needs a computer	1	0.1%	5.9%
Other:	2	0.1%	11.8%
Child safety: Personal	2	0.1%	
Child safety: Home	8	0.6%	
Child safety: Guns	7	0.5%	
Child safety: Water	9	0.6%	
Child safety: Other:	32	2.3%	
General	30	2.1%	
Radon in home	1	0.1%	
Bike	1	0.1%	
Drug/alcohol use by child	1	0.1%	
Drug/alcohol use by self	2	0.1%	
Quit smoking for self	21	1.5%	
Child's smoking	0	0.0%	
Other:	27	1.9%	
"Fitting in"	2	0.1%	
Breastfeeding	1	0.1%	
Grades	1	0.1%	
Paying utilities	3	0.2%	
Car seat information	4	0.3%	
Legal troubles	1	0.1%	
Child with weight problems	1	0.1%	
Potty training	1	0.1%	
Cash assistance	1	0.1%	
Information on formulas	1	0.1%	
School insists on insurance	1	0.1%	
Respite care	2	0.1%	
Home with no heating	1	0.1%	
Parent's mental health	3	0.2%	
Diaper service	1	0.1%	
Single mom issues	1	0.1%	
Low iron levels	1	0.1%	
Milk intolerance	1	0.1%	
Total:	**1404**	**100%**	

APPENDIX D

MCA 2001 Issue Scoping Survey

Please indicate the level of interest you or your group have in pursuing the issue areas below as a part of the 2001 Montana's Children Agenda. If you indicate an interest an issue area, please describe briefly what specific actions, proposals or facets of the issue you will be most interested in. When you have finished, please take another minute to add issues of interest or concern to you or your organization that have not been included elsewhere on the survey. Thank you!

Levels of interest are categorized very generally as follows:

1 - A critical issue area for me or my organization. We will/want to play a lead role or be very active in this area.

2 - An important issue area for me or my organization. We will likely be active and/or supportive in this area.

3 - No specific interest at this time, but we will analyze available information and may be active and/or supportive on the issue later.

0 - I/we have no interest in pursuing this issue area at this time.

1. **Children's Health Insurance** 1 2 3 0

   Specific Issues: _____

2. **Dental Access** 1 2 3 0

   Specific Issues: _____

3. **Tobacco Use Prevention** 1 2 3 0

   Specific Issues: _____

4. **Mental Health Managed Care** 1 2 3 0

   Specific Issues: _____

5. **Foster Care** 1 2 3 0

Specific Issues: _____

6. **National Guard Youth Challenge** 1 2 3 0

Specific Issues: _____

7. **HMO Network Adequacy** 1 2 3 0

Specific Issues: _____

8. **Welfare Reform/FAIM II** 1 2 3 0

Specific Issues: _____

9. **Highway Injury & Death** 1 2 3 0

Specific Issues: _____

10. **Direct Entry Midwifery** 1 2 3 0

Specific Issues: _____

11. **Child Care** 1 2 3 0

Specific Issues: _____

12. **Local Data re: Children's Health** 1 2 3 0

Specific Issues: _____

13. **Hunger/Nutrition** 1 2 3 0

Specific Issues: _____

14. **Child Support Enforcement** 1 2 3 0

Specific Issues: _____

15. **Juvenile Justice** 1 2 3 0

Specific Issues: _____

16. **Education Policy** 1 2 3 0

Specific Issues: _____

17. _____ 1 2 3 0

Specific Issues: _____

18. _____ 1 2 3 0

Specific Issues: _____

19. _____ 1 2 3 0

Specific Issues: _____

20. _____ 1 2 3 0

Specific Issues: _____

21. _____ 1 2 3 0

Specific Issues: _____

Name: _____ **Organization:** _____

Please mail to MCA, P.O. Box 876, Helena, 59624 or fax to 406/443-0979

1. **Children's Health Insurance**	1 70%	2 20%	3 10%	0

Specific Issues: Continuing outreach efforts
Broadening the program to include up to 200% of the FPL

2. **Dental Access**	1 60%	2 30%	3	0 10%

Specific Issues: Shortages of dentists and hygienists
Reimbursement rates

3. **Tobacco Use Prevention**	1 40%	2 50%	3	0 10%

Specific Issues: Dedicating settlement money to health care issues
Establishing a settlement trust
More focus on prevention of smoking in pregnant women

4. **Mental Health**	1 40%	2 40%	3 10%	0 10%

Specific Issues: Lack of prioritized spending & programs
Access for children to appropriate levels of care

5. **Foster Care**	1 40%	2 30%	3 30%	0

Specific Issues: Support and funding for foster care parents
Better medical benefits for foster care children

6. **National Guard Youth Challenge**	1	2 10%	3 70%	0 20%

Specific Issues: Cost effectiveness

7. **HMO Network Adequacy**	1	2 10%	3 70%	0 20%

Specific Issues: Not much impact in Montana, so far

8. **Welfare Reform/FAIM II**	1 30%	2 30%	3 40%	0

Specific Issues: Concern over federal changes
Candid evaluation: reducing welfare or ending poverty?

9. **Highway Injury & Death**	1 10%	2 30%	3 60%	0

Specific Issues: Graduated drivers licensing

10. **Direct Entry Midwifery**	1 10%	2 20%	3 40%	0 30%

Specific Issues: Changes needed on 72 hour reporting form and process

11. **Child Care**	1 30%	2 40%	3 30%	0

Specific Issues: Quality - training, accreditation
Access
Provider payments
Total system review

12. **Local Data re: Children's Health**	1 70%	2 10%	3 20%	0

Specific Issues: Critical for legislative support
Include environmental hazards

13. **Hunger/Nutrition**	1 20%	2 50%	3 30%	0

Specific Issues: Local food banks all needing more food
Thermometer for welfare reform?

14. **Child Support Enforcement**	1 10%	2 40%	3 50%	0

Specific Issues: Performance issues -- website working? Cost efficient?
What federal changes will come next?

15. **Juvenile Justice**	1 20%	2	3 80%	0

Specific Issues: Fix loophole in death penalty exclusion

16. **Education Policy**	1 10%	2 10%	3 80%	0

Specific Issues: Dealing with more and greater levels of violence
Programs for autistic, speech/language impaired children
Weapons and guns on school grounds

APPENDIX E

Healthy Mothers,
Healthy Babies
The Montana Coalition

316 Fuller Avenue • P.O. Box 876 • Helena, MT 59624
(406) 449-8611 • Fax (406) 449-3703

HEALTHY MOTHERS, HEALTHY BABIES
THE MONTANA COALITION

CHILDREN'S DENTAL HEALTH COMMITTEE

COMMUNITY SURVEY OF MONTANA DENTISTS

JUNE 1998

Community Survey of Montana Dentists June 1998

Background

In June 1998 a mail survey was sent to all 551 member dentists of the Montana Dental Association. 134 responses were received. Three were from retired dentists and not completed so the survey sample is from the 131 completed questionnaires, or 24% of those sampled. Since the responses were not random a probability rate can not be assigned.

Questionnaires were received from 23 Counties:

County	Frequency	Percent	County	Frequency	Percent
Beaverhead	1	1%	Liberty	1	1%
Blaine	1	1%	Lincoln	1	1%
Cascade	1	1%	Mineral	1	1%
Daniels	13	10%	Missoula	24	18%
Dawson	1	1%	Phillips	1	1%
Deerlodge	1	1%	Pondera	1	1%
Fergus	2	2%	Powell	1	1%
Flathead	10	8%	Richland	1	1%
Gallatin	4	3%	Sheridan	1	1%
Hill	5	4%	Silver Bow	6	5%
Lake	2	2%	Yellowstone	36	28%
Lewis & Clark	10	8%	Co. not known	6	5%

Results of Survey

Q 1. My practice is:

	Frequency	Percent
A general dentist	119	91%
A pediatric dentist	6	5%
Other dental specialists	6	5%

Q 2. I practice dentistry in a city of:

	Frequency	Percent
under 1,500 people	6	5%
1,500 but under 5,000	19	15%
5,000 but under 20,000	22	17%
20,000 but under 40,000	28	21%
40,000 people and over	54	41%

Q 3. How many years have you been in practice?

	Frequency	Percent
Less than one year	3	2%
Less than five years	18	14%
Less than ten years	9	7%
More than ten years	99	76%

retired	3	2%

5. What percentage of office visits during a typical week are private pay?

Frequency Percent	Frequency	Percent
More than 90%	53	40%
between 70% and 90%	41	31%
between 50% and 70%	14	11%
less than 50%	3	2%
not answered	20	15%

Q 6. What percentage of office visits during a typical week are donated?

	Frequency	Percent
between 10% and 20%	16	12%
between 5% and 10%	27	21%
less than 5%	35	27%
none or no answer	53	41%

Q 7. What percentage of office visits during a typical week are at reduced fee?

	Frequency	Percent
between 20% and 40%	6	5%
between 10% and 20%	12	9%
between 5% and 10%	15	11%
less than 5%	22	17%
none or no answer	76	58%

Q 8. What percentage of office visits during a typical week are Medicaid?

	Frequency	Percent
between 25% and 50%	10	8%
between 10% and 25%	30	23%
between 5% and 10%	20	15%
less than 5%	23	18%
none or no answer	48	37%

Q 9. Do you see young children?

	Frequency	Percent
Yes	119	91%
No	10	8%
no answer	2	2%

Community Survey of Montana Dentists June 1998

Q 10. Do you participate in any programs or volunteer dental care for the indigent or children?

	Frequency	Percent
Yes	96	73%
No	30	23%
no answer	5	4%

Q 11 through 21 Which type of services do you volunteer for?

	Frequency	Percent
Donated dental services for disabled or elderly	79	63%
Deering Clinic (Billings)*	7	5%
Breakfast Exchange (Billings)*	16	12%
Lewis & Clark Co-op Dental **	6	5%
Partnership Clinic (Missoula)***	8	6%
In-school screenings	50	38%
Caring Program for Children	26	20%
Head Start	57	44%
School Based Dental	53	41%
Community based dental ed.	36	27%
Other programs****	18	14%

* 19% of Yellowstone respondents stated they donated services to the Deering Clinic
44% of Yellowstone respondents stated they donated services to the Breakfast Exchange.

** 50% of the Lewis and Clark County respondents stated they donated services to the Lewis & Clark Co-op dental clinic

*** 33% of Missoula County respondents stated they donated services to the Partnership Clinic

**** Other programs mentioned:
Doctor With A Heart Free Day
Doing local screenings
Children's Dental Health
Providing services regardless of payment
CDC Well Child
Community Health
Selected local programs
Migrant program
Nursing homes
Services to the developmentally disabled

Q 22. Would you attend continuing education to assist you in treating young children (birth through age 4)?

	Frequency	Percent
Yes	68	52%
No	50	38%
Depends	2	2%
No answer	11	8%

Medicaid Questions

Q 23. At the present time, I will see:

	Frequency	Percent
all Medicaid patients who seek me out	22	17%
only established Medicaid patients	71	54%
do not see Medicaid patients	27	21%
only children on Medicaid	3	2%
no answer	8	6%

Q 24 through 31. Do you see patients/children who are on Medicaid?

	Frequency	Percent
Adults (those over 18 years)	69	53%
Disabled	82	63%
Elderly (over 65 years)	69	53%
Children under 5 years	81	62%
Children between 5 and 18	92	70%
Children in pain and/or infection	88	67%
Children only on limited basis	23	18%
Do not see Medicaid patients	28	21%

Q 32 through 36. I do not see Medicaid patients because: *(Rate importance from 1 to 5 with 5 being most important)*

	5	4	3	2	1	n/a
The fee is too low given the average overhead	45%	7%	4%	3%	5%	37%
Medicaid patients tend to be a high no-show appointment	.31%	18%	8%	5%	2%	36%
Paperwork takes too much time and hassle	15%	13%	11%	11%	10%	41%
It takes too long to get paid for the performed services	8%	5%	8%	15%	17%	47%
Behavior/attitude/hygiene - objectionable to work with in terms of personal and oral hygiene, because of lack of education	13%	3%	10%	10%	18%	47%

* These answers should only be used for trending because there was some misunderstanding of the instructions. Some respondents rated each question 1 - 5 and some rated the series of questions 1 - 5.

Q 37. If it was available, would you be interested in working with public health nurses to assist in ensuring your low income children attend your scheduled dental appointments, receive dental hygiene education, and provide monitoring of your suggestions?

	Frequency	Percent
Yes	61	47%
No	34	26%
Maybe	3	2%

No answer	33	25%

Q 38. What would encourage you to begin or increase the number of Medicaid patients you take?

Categorized Answers *(We categorized answers into three groups for tabulation purposes)*

	Frequency	Percent
Increase fee	28	21%
Pay, paperwork and compliance	32	24%
All others -less than 2 responses	25	19%
No answer	45	34%

Actual comments:

Increase fee level. Now rarely cover overhead therefore lose $ seeing them. Mainly adults.

Reasonable pay. Less paperwork. Patient compliance.

Improve 32 through 35

Higher fee reimbursement. Better attitude from patients.

Fee level no show decrease

Fee level. No shows. Less paperwork.

Better fees. Fewer no shows.

Treatment options that actually benefit the patient. Not just stopgap care.

Fees, no shows, paperwork

A voice in how the program is managed

When I am already too busy I sure don't need patients that are more hassle for less pay.

Increase fees paid

Address 32-36

Increased cooperation and fees

If they would be more responsible to keep appointments and do their part in oral hygiene

Cut down paperwork and change requirements for service to be rendered

Pay current fees

Perhaps donate more of new. Currently limited to certain procedures

Nothing

Increase fee levels

Nothing

I prefer to donate my services to those I believe need it.

To see an adult I never break even with materials.

Pay my fee for service. Give reimbursement for hygiene instruction.

Higher reimbursement rate. Penalty for no shows

Increase fee payment schedule. Medicaid patient have a tendency to schedule appointments and not show.

Q 38. Actual comments continued:

Reimbursement, attendance, Payment to surgery centers with same rate as outpatient centers.

We refer our Medicaid children to pediatric dentist locally.

My partner and myself are the only doctors taking care of Medicaid patients in this town.

Realistic fee schedule

Nothing- I only work limited hours.

Change fee schedule. Increase responsibility of parents. I don't think #37 would help

Increased fees reimbursements

If I had more time. My practice is booked out about three months in advance.

Fees. Get rid of Consulted. eliminate all preauthorization requirements.

Penalties to patients for no shows.

Better fees

Fee increase. Guaranteed show up or pay for broken appointment

Better fees. Better compliance with keeping appointments.

Increase compensation

Better fee schedule.

Fees, tax credit for non-reimbursement, Keep appointments.

Making fees usual and customary.

Remove the financial burden

Fair fee schedule. 90% of UCR

Nothing

Total patient load drops

Increase fees.

Other dentists caring for their fair share of Medicaid patients.

Comparable fees for service.

Higher fee schedule

Have more than my share at present.

Increased fees

Fewer regulations.

Nothing

Fair fees

Fee schedule commensurate with National Fee Network.

Increase fee schedule. The fees don't even pay a hygienist's wages.

Dollar amount paid. Sincere patients, not just 'band aid' work.

Q 38. Actual comments continued:

Private, unpaid volunteers administering the program. It was only when government got involved that anyone was paid for these services, formerly donated, Now fewer are cared for because we pay others to "administer

A better fee. Treatment per judgment of dentist- not fee.

Fee structure somewhere at least break even.

Increased fee schedule

Fee schedule, no shows, timely reimbursement

Increase fees, and patient knowledge of value of services they receive.

I take them all

I never turn down.

The system would have to change drastically. I would want the right to choose who I would treat and be able to refuse treatment to who I don't want to treat.

Because of past experiences (20 years). Nothing!

Nothing

Fees, no shows, paperwork, Attitude

Other dentists to reduce the numbers trying to get in

Enrollment bonus

At this time, do not take any new patients

Increase payment rates by a multiple of 3. Decrease hassle and amount of time to get paid. Issue state tax credit to Medicaid.

We see 20% already.

Payment for missed appointments.

Increase fees.

Nothing

Increase fee schedule and assure attendance for appointments.

All Medicaid is volunteer portion of practice. See survey

Limit the number of services provided and pay our rates for services

I feel the record shows since 1981 I have seen more than my share by far.

Fair fee schedule. Less paperwork.

No contact -let me pick and choose my charities, not the state

Compensation commensurate to treatment/care provided

A more equitable fee for service

Increase reimbursement fees

Raise fee level to cover overhead

Less hassle with claims and more competitive fees

Reduce no show rate significantly

Q 38. Actual comments continued;

A change in 32-36 I don't mind donating some services, but failed appointments and poor home care compliance and attitudes are discouraging.

Fees high enough to cover expenses and less paperwork and guaranteed of pay.

Pay child rate for dentistry and allow charge for "no shows"

Less hassle with Helena on forms

Q 39. Some states pay dentists an enrollment bonus to ensure dentists are willing to provide care to Medicaid eligible children. Would you be willing to take more Medicaid children with this type of incentive?

	Frequency	Percent
Yes	28	21%
No	59	45%
Maybe	5	4%
No answer	39	30%

Q 40. What are your suggestions to improve access to dental care for children?

Categorized answers *(We categorized the answers into six groups for tabulation)*

	Frequency	Percent
Educate patients	19	15%
Pay-paperwork-compliance	17	13%
Parents preparation of children	4	3%
Need all dentists to share load	4	3%
All others (one answer)	6	5%
No answer	81	62%

Actual comments:

Educate parents on importance of dental care. Govern- ment and aided programs with appropriate reimbursement.

same answer

The biggest problem I have with Medicaid children is that their parents have done a very poor job of preparing them for the appointment. They scare them.

Educate parents. Several children fall victim to parent irresponsibility.

Education and to increase Medicaid fees.

More providers with higher fees and cooperation

Unfair to provider and existing patients to expect quality care for substandard reimbursement.

To compensate dentists for taking patients at a loss then be able to write the loss off on taxes.

Q 40 Actual comments continued:

Caring program, open up to other insurance companies in addition to BC for compensation.

Make it mandatory for families on Medicaid to have medical/dental visits or lose benefits. The utilization rate is low for children. That needs to be improved. The reimbursement levels are more than reasonable for children, but inexcusably low for adults in addition to the limitations of care reimbursement for adults.

Get everyone to share the load. All dentists mandatory.

I think that Billings children should have access to care through the existing programs. Breakfast Exchange, etc.

Encourage all dentists to participate in the various programs

Money.

Advertise

Mandated regular care and to follow through with work.

See Survey

Education on dental care for the entire family.

Develop a financial plan to eliminate the cost to taxpayers

Better fees. public health services, in-school education. School nurse training.

Increase fees. Parents more responsible about getting patients here for their appointment.

Increased fees, means of being certain child would be there.

Clinics

Fair fees.

All dentists take a portion of patients on Medicaid.

Increase fee reimbursement significantly to try to attract more dentists to see Medicaid children.

I proposed this to Congress years ago: eliminate all programs then allow providers to have direct tax write offs for caring for those unable to pay. (Taxes collected from medical professionals are less than 17% of all taxes collected.) This would encourage all, or mostly all, to participate, lighten loads for everyone, eliminate a vast, inefficient bureaucracy and provide care on a broader basis to the needy. The response from Congress was disturbing and foretelling of present problems, all unnecessary.

Continued education at school. Follow-up where possible by health officials and auxiliaries.

Fees and parents who care and appreciate the value of dentists' time and effort

Improve appointment reliability.

Educate Medicaid parents to teach their children good oral hygiene. Parents generally do not accept the responsibility for the neglect of these kids and do not insist that they brush and floss.

Education of parents on priorities.

Q 40. Actual comments continued;

Educate in school and educate parents.

Parents need to support us with behavior problems

Give every dentist a toothache for a weekend

Increase fee schedule. Educate parents upon enrollment of necessity of dental care for their children.

Improve behavior and manageability as patients.

Improve reimbursement so dentists depending on income from providing these services can justify them.

Fund the program so more young dentists desire to treat these patients as I did 15 years ago, in 1981 I would have advertised for Medicaid patients. I have lots of ideas on how to make it work, but the above is the obvious choice.

Better education for parents and grandparents.

Better education of parents and fair fee schedules.

Reimburse dentists at a more appropriate fee

More equitable fee for services.

Increase fees

Fees too low. Raise level to 70% of UCF

Better parents

Pay a fee for no shows

Workers Compensation Questions

Q 41. Do you accept workers compensation cases for your practice?

	Frequency	Percent
Yes	45	34%
Yes, but only patients of record	49	37%
No	30	23%
No answer	7	5%

Q 42. If you don't accept workers compensation, what is the primary reason?

n=67	Frequency	Percent
Low reimbursement	22	33%
Paperwork and management	8	12%
Both reasons	26	39%
Other*	11	16%

Q 42. Other by comment

Fee levels and no-shows main reasons we would consider dropping Medicaid. Number 41, payment reimbursement very low. we don't have that many cases have considered not accepting these cases.

The fee scale is a joke. Example, recent case: Normal fee $3500. Lab fees $1300 the case Workman's Comp paid $1900

I haven't encountered a case yet.

Unfair to existing patients who get the same treatment but are fully responsible themselves. Should have a co-pay. Workers' Comp is grossly behind in their reimbursement schedule for the kind of care they are expecting us to provide.

Children only.

Workers' Comp should be between the employee/employer, not the dentist.

95% of my practice is pediatric.

The money and getting rid of Consulted are equally important.

Medicaid fee schedule.

Not always. Will cover what needs to be done.

The state always seems to have the right to ask for reimbursement back once treatment is provided.

Employer should pay non co-payment, not the dentist.

If workers' Comp paid fees, then no problem with treating. However, we select our own "charity" and will not have "charity" imposed on us. Our practice is a business and we don't believe in "cost shifting" or imposed "charity" on to private fees for serving patients.

Fee schedule should be updated.

Workers' comp is way out of line to expect dentists to supplement their insurance company.

Has never come up.

Takes forever to get reimbursed.

Pediatric practice. No opportunity to treat adults

Low fees. Micro-management of cases by adequately trained clerks.

I treat children.

Employees pay a lot of money for Workers' Comp. When employees get injured, the dentist must donate services and lose money to help those people. Why does Workers' Comp not cover the cost completely? Workers' Comp wins, the patient wins, the dentist loses. It does not make sense.

What they approve as treatment is usually below standard care and reimbursement takes forever. Medicaid is a far better program than Workers' Comp.

We have never gotten paid for those cases. Ever.

Workers' Comp not willing to provide standard care at normal fees.

General Comments

- The reason I do not take Medicaid patients of all ages is that Medicaid terminated me from their program because I wanted to have them treat a patient for alcohol, drug abuse, child abuse, and spouse abuse. They refused and threatened to take my license two weeks later. I was sent a letter of termination. It was their decision, not mine.
- If you really want equal service opportunities, you must be equal and no more hassle than we have with other patients.
- Provide emergency treatment only for adults. A lot of money has been spent doing root canals on teeth that are never restored. I would prefer to see this money go to clinics to provide better care to indigent children. (Note)
- There has to be some incentive to see Medicaid patients from the state. I have enough fee for service patients that I do not need Medicaid patients to fill my schedule. Be realistic, to run a dental office is very expensive per hour. One can only take so many patients out of the goodness of their heart.
- We are phasing Medicaid out of our practice over the next two years for all these reasons, but especially 32 through 36.
- Medicaid children in our practice are very young. Most have to be sedated for treatment and have probably up to 4x as much work as the general public. failed appointments and low reimbursements are still issues. In addition, we go to the hospital once monthly, usually doing 5 Medicaid cases of young children with rampant decay under the age of 2 years(plus or minus 6 months. We are very disappointed that Medicaid has not paid our Surgery Center for the Medicaid cases for the past 6 months and the rate of payment they are going to provide will be $237 compared to $835 to the hospital for the same service. If this problem is not resolved, we will not take the children through Medicaid. They will have to pay the Surgery Center fee. We would appreciate your addressing this issue. Additional note to increase Medicaid attendance:
  we have a policy of charging $25 for failed appointments (after the first, which is free. we were making headway with attendance with this policy until it was declared that we cannot charge Medicaid for a failed appointment. We thus dismiss at the second failed appt.
- Medicaid- the patients we treat we do not file for payment due to low fees and paperwork. We just do them no charge. I am only taking new patients by referral from other dentists or from existing patients.
- The Workers' Comp program is workers' compensation in name only. The program has been gutted - thanks to Rick Hill. It is apparent that the government dental programs do not value dental health as an important aspect of health care, and have no appreciation or respect for dentistry and dentists, as they think we should work for below cost or even for free. Why is it that in the community health centers the only health care providers that are being asked to work for free are dentists? Why not physicians, nurses, staff? does anyone who is employed at the Department of Public Health and Human Services work for free?
- Teaching personal responsibility is part of education. "Hand holding" and making excuses for this population does not teach anything. When do people start taking personal responsibility?
- I work only part time, and considering complete retirement.
- All of these reasons are true for Medicaid patients and I do see them, but it's hard to justify.
- Have not turned away any Medicaid eligible children if they would be scheduled
- Even though I take Medicaid patients, questions 32 through 36 are vary valid.

- I saw a large number of Medicaid patients for over 6 years. I would like to be positive and help, but I'm sick of the whole system. It is mismanaged, abused, and I'm not interested in
- dealing with it any more. I'm amazed at the individuals that are on it and disgusted with some that need to be but can't.
- 32 through 36 are all problems that interfere with these people receiving services. As you can see, half the trouble is because of the attitude of the Medicaid patient or parent. We did work with, and receive excellent help from local public health, social workers, and Head start personnel. Unfortunately, they too were stonewalled by the apathy of the parents.
- See anyone for pain. Medicaid very discouraging- pay is insulting and Medicaid patients not very reliable for appointments. Prefer the clinic setting as more straightforward approach to charity dentistry.
- Number 1 reason- Medicaid made us sign a contract with too many unexplained rules and regulations. I was unsure of what I was signing so I didn't sign.
- Medicaid fees for adults are so low it doesn't even cover our costs. a definite problem for dentists.
- If any answers are confusing or outside the knowledge base, I would be glad to talk with you.
- I plan on donating my time at our CCH facility which will open this December. Hopefully, this nit will assist those in need and provide services for many patients in all categories.
- I spent 3 years in the PHS IHS program. We allocated funds to children and teenagers with an emphasis on preventative services. Adult care was emergency only and restorative mostly during school vacations. prioritize care and allocate your limited funds.
- If parents are not interested enough to bring and participate with their children's appointments, having the school nurse monitor kids only provides short term benefits. Parents must get involved to have any long term educational benefit.
- General problems: Patients no shows and late, complain about having to pay their one dollar per procedure, bad attitudes, patients come in drunk or on drugs, did not wash or brush teeth, tobacco in mouth, fowl language, many patients bragged about not working and making more on welfare than if they had a job. Many worked and collected welfare benefits, many single moms had several kids and lived with the fathers so they could collect more money. One patient collected benefits using 5 different names. I quit treating Medicaid patients completely because the state said I had to treat all or none, and I had more deadbeats that truly needy patients.
- They've been educated in the schools and dental offices. It's lack of discipline
- I am 80 years old but enjoy my small volume dental practice. I am out of the office quite often and am not booked very far in advance. I have never refused Medicaid patients unless I refer them for orthodontic treatment.
- Good survey. I hope the results will be made available to dentists.
- There is no free lunch. If you want care it needs to be paid for. The better the payment, the better and more accessible the care. Very simple.
- I would treat Medicaid patients if some method of assuring them keeping their appointments was initiated. The failure rate was very high.. "slept in, forgot, sick," etc.
- We do not take new patients, Medicaid or self pay.
- As a former provider and dentist of 26 years, you should understand that government has no idea what it takes to run a dental office. Nobody appreciates something given for free.

- Providers just cannot be expected to provide services on the present fee schedule- it's just a very sad, losing proposition.

- Our office is currently not accepting new patients therefore we only see Medicaid patients of record.
- Because I am old and my practice is large, I take very few new patients whether they are Medicaid or not. I continued to take new Medicaid patients who are disabled and suffer severe disabling mental illness.
- Provide basic education to new mothers at the hospital when their babies are born and work with pediatricians. Have them be aware that young children need dental care and tell the moms to take them in for early exams and preventive care and education by dental staff.

COMMUNITY SURVEY OF MONTANA DENTISTS

HEALTHY MOTHERS, HEALTHY BABIES

CHILDREN'S DENTAL HEALTH COMMITTEE

June, 1998

INTRODUCTION: This survey is being conducted by Healthy Mothers, Healthy Babies, Children's Dental Health Committee which includes, the Montana Dental Association, County Health Departments, Montana Head Start Association, the Medicaid and the Family and Community Health Bureaus of the Department of Public Health and Human Services, and Montana pediatric dentists interested in children's dental health access. We are hoping to learn your opinions about children's dental health, gathering base line information and providing the results back to you. Your responses are very important if we are to include dental health in the Children's Health Insurance Program.

1. My practice is
   - ☐ 1. a general dentist
   - ☐ 2. a pediatric dentist
   - ☐ 3. other dental specialist

2. I practice dentistry in a city of:
   - ☐ 1. under 1,500 people
   - ☐ 2. 1,500 people but under 5,000 people
   - ☐ 3. 5,000 people but under 20,000 people
   - ☐ 4. 20,000 people but under 40,000 people
   - ☐ 5. 40,000 people and over

3. How many years have you been in practice?
   - ☐ 1. Less than one year
   - ☐ 2. Less than five years
   - ☐ 3. Less than ten years
   - ☐ 4. More than ten years

4. At the present time, and with two to four weeks vacation per year, I practice an average of
   - ☐ 1. less than 16 hours per week
   - ☐ 2. 16 hours but less than 32 hoursper week
   - ☐ 3. 32 hours per week but less than 40 hours per week
   - ☐ 4. more than 40 hours per week

What percentage of office visits during a typical week are:

5. _____% Private pay (insurance/ cash)

6. _____% Donated

7. _____% Reduced fee (non-managed care)

8. _____% Medicaid caseload

9. Do you see young children?
   - ☐ 1. Yes
   - ☐ 2. No

10. Do you participate in any programs or volunteer dental care for the indigent or children?
    - ☐ 1. Yes
    - ☐ 2. No

If yes, please answer questions 11 through 21, if no skip to question 22.

Which types of services do you volunteer for *(check all that apply)*

11. Donated Dental Services (disabled, elderly)
    - ☐ 1. Yes

12. Deering Clinic (Billings area)
    - ☐ 1. Yes

13. Breakfast Exchange Program (Billings area)
    - ☐ 1. Yes

14. Lewis and Clark Co-Op Dental Clinic (Helena area)
    - ☐ 1. Yes

15. Partnership Clinic (Missoula area)
    - ☐ 1. Yes

16. In-school screenings
    - ☐ 1. Yes

17. Caring Program
    - ☐ 1. Yes

18. Head Start
    - ☐ 1. Yes

19. School based dental health education
    - ☐ 1. Yes

20. Community based dental education
    - ☐ 1. Yes

21. Other programs

    _____

    _____

    _____

I would like information on above programs

_____

_____

_____

22. Would you attend continuing education to assist you in treating young children (birth through age 4)?
    - ☐ 1. Yes
    - ☐ 2. No

Following are some questions about Medicaid Patients

23. At the present time, I will see
    - ☐ 1. all patients who seek me out who have a Medicaid card
    - ☐ 2. only see established patients of record who have a Medicaid card
    - ☐ 3. not see any patients who have a Medicaid card

Do you see patients/children who are on Medicaid? *(Select all that apply)*

24. Adults (+18 years of age)
    - ☐ 1. Yes

25. Disabled
    ☐ 1. Yes

26. Elderly (over 65)
    ☐ 1. Yes

27. Children (age: birth to under 5)
    ☐ 1. Yes

28. Children (age: 5 to under 18)
    ☐ 1. Yes

29. Children in pain and/or infection
    ☐ 1. Yes

30. Children only on a limited basis
    ☐ 1. Yes

31. Do not see Medicaid patients
    ☐ 1. Yes

I do not see Medicaid patients because *(Rate importance from 1 to 5 with 5 being most important)*

32. ____ The fee level is too low given the average overhead

33. ____ Medicaid patients tends to be a high no-show appointment

34. ____ Paperwork takes too much time and hassle

35. ____ It takes too long to get paid for the performed services

36. ____ Behavior/attitude/hygiene – objectionable to work with in terms of personal and oral hygiene, because of lack of education

37. If it was available, would you be interested in working with public health nurses to assist in ensuring your low income children attend your scheduled dental appointments, receive dental hygiene education, and provide monitoring of your suggestions?
    ☐ 1. Yes
    ☐ 2. No

38. What would encourage you to begin or increase the number of Medicaid patients you take?

    _____
    _____
    _____
    _____

39. Some states pay dentists an enrollment bonus to ensure dentists are willing to provide care to Medicaid eligible children. Would you be willing to take more Medicaid children with this type of incentive?
    ☐ 1. Yes
    ☐ 2. No

40. What are your suggestions to improve access to dental care for children?

    _____
    _____
    _____
    _____

To save resources we have included two questions from the Montana Dental Association. We would appreciate your answers to the following questions:

41. Do you accept workers compensation cases for your practice?
    ☐ 1. yes
    ☐ 2. yes, but only from patients of record
    ☐ 3. no, do not accept

42. If you don't accept workers compensation, what is the primary reason?
    ☐ 1. low reimbursement
    ☐ 2. paperwork/treatment management by payor
    ☐ 3. other (please explain)

    _____
    _____
    _____
    _____

COMMENTS:

THANK YOU FOR COMPLETING THIS SURVEY

HEALTHY MOTHERS, HEALTHY BABIES
CHILDREN'S DENTAL HEALTH COMMITTEE
316 Fuller Avenue
P. O. Box 876
Helena, MT 59624

Please return the completed survey by July 15, in the enclosed envelope to:

Healthy Mothers, Healthy Babies
The Montana Coalition
P. O. Box 876
Helena, MT 59624

Or FAX 406-449-3703

APPENDIX F

SUICIDE ISSUES: RELATED TO ESTIMATED INCIDENCE AND AVAILABLE RESOURCES WITHIN COUNTIES

Unfortunately, there appears to be no distinct trend related to county size and suicide incidence. It is an issue that strikes at small counties (Prairie, #1), mid-range counties (Powell, #2), and the larger counties (Silver Bow, #4) of Montana. The following table lists the counties that had a suicide incidence close to 0.1 or greater for the period between 1989 and 1997.

COUNTY	# SUICIDES (1989-1997)	1997 POP.	ESTIMATED INCIDENCE
Prairie	4	1335	0.300
Powell	16	7072	0.226
Wibaux	2	1106	0.181
Silver Bow	59	34441	0.171
Meagher	3	1805	0.166
Mineral	6	3725	0.161
Wheatland	3	2333	0.129
Lewis & Clark	67	53251	0.126
Liberty	3	2391	0.125
Missoula	101	88818	0.114
Custer	13	12115	0.107
Yellowstone	131	125771	0.104
Broadwater	4	4083	0.098
Cascade	77	79134	0.097
Hill	17	17538	0.097
Valley	8	8295	0.096
Golden Valley	1	1051	0.095
Lake	24	25341	0.095

Although, the incidence is estimated, because a lack of having the 1989-1997 average population of each county, it would still be a fairly accurate picture of the actual suicide incidence across the different counties.

We also have a list of counties that responded to a survey in which they self-reported methods of intervention resources—according to whether it be prevention, intervention, or postvention, or none at all. The following is a list of the counties that have been determined to have a higher incidence of suicide.

COUNTY	PREVENTION	INTERVENTION	POSTVENTION	NONE
Prairie	1	1	1	0
Powell	No response	No response	No response	N.R.
Wibaux	No response	No response	No response	N.R.
Silver Bow	2	2	2	0
Meagher	No response	No response	No response	N.R.
Mineral	1	0	0	2
Wheatland	0	1	0	1
Lewis & Clark	1	2	2	2
Liberty	0	0	0	3
Missoula	3	3	2	1
Custer	0	0	0	1
Yellowstone	3	5	3	1
Broadwater	1	1	1	3
Cascade	1	1	1	3
Hill	1	1	1	1
Valley	3	3	3	2
Golden Valley	No response	No response	No response	N.R.
Lake	1	2	1	3

Prairie is a very small county, but had four people within the ages of 15-24 commit suicide within the last 9 years. This high of an incidence would not be due to low population numbers, but is rather suggesting that more prevention needs to be taking place.

Powell is a mid-range sized county, that has had most of their suicides occurring in people aged 25-44, these are the parents, workers, etc. that are dealing with this issue most heavily in Powell. Unfortunately, we have no data indicating that they have any established intervention methods of some kind in place within this county.

Wibaux's issues could be related to very small population numbers causing the higher incidence. We also have no knowledge of any intervention methods taking place within Wibaux.

Silver Bow is one of the larger counties within Montana. Their occurrences of suicide are spread out through the various age brackets. Of note though, is their relatively high number of adolescent suicide (10), within 1989-1997. They also have one of the higher numbers of established intervention methods compared to the rest of the state, which is discouraging when relating it back to their suicide incidence.

Meagher is another very small county, but I believe that with three suicides, their incidence number is an accurate reflection on their suicide issue. Once again, though there was no responses as of yet to indicate whether or not they have appropriate resources to deal with this problem. It is, however, the smaller counties that appear to not have as many, or any, established intervention methods when dealing with this issue.

Mineral is a smaller county, and most of their suicides have occurred in the older age divisions. There was also some disagreement between the reported responses regarding whether or not there are any established intervention methods within their county, which could be one of their major problems related to suicide—if someone came for help, no one would know where to turn to?

Wheatland is also a smaller county, but they are seeing higher rates of suicide than we would like. Also of major concern are the two suicides they had in the 10-14 age bracket. That is the same amount that larger counties such as Yellowstone and Flathead have seen. This is very much an issue for Wheatland that demands attention, especially in light of the minimal intervention methods they have in place there.

Lewis and Clark county is one of the larger counties, with their suicide issue spread out across the age brackets. They have, however had quite a large amount of suicides in the 15-19 age division, with 12, which is second in the state. They also seem to focus their efforts more in intervention and postvention methods, rather than in prevention. They also have a couple of organizations that are unaware of any intervention methods in their community, which is a problem, as we have stated before.

Liberty is another smaller county with suicides happening in the older population, and no recognized method of intervention.

Missoula is a large county, with a significant majority of their suicides occurring within the 25-44 age bracket. Ironically though, they have quite a few reported intervention methods within the county.

Custer is a mid-sized county. Their suicides are relatively spread out, but do lean more heavily towards the younger ages. Unfortunately, they also report no established form of intervention within the county.

Yellowstone is the largest county within the state of Montana. Their suicide incidence is also spread out within the age divisions, but of note are the two suicides they had within the 10-14 age bracket. They also have the second highest reported number of established intervention methods within the state.

Broadwater is a smaller county with most of their suicides happening within the older ages. They also report having prevention, intervention, and postvention resource methods to combat suicide, but for every one response for these methods, someone stated they knew of no method within their county.

Cascade is a larger county with their suicides not discriminating against age. Sadly, they have the highest number of suicides occurring within the 10-14 age bracket, with three. They also have the same issue that Broadwater is having regarding their reported resource methods, with half reporting they have one of some kind, the other half reporting they know of none.

Hill is of mid-range county size. Their suicides are also relatively spread out. They also report resources occurring in all three levels of intervention.

Valley is a small to mid-sized county. Their suicide incidence is also relatively spread out. For a smaller county though, they have one of the highest levels of reported resources to deal with the issue of suicide, which is quite surprising, but a very encouraging thing. Hopefully they will begin to see a decline in their suicide incidence, as a result of these programs.

Golden Valley is a very small county, so with only one reported suicide, it caused a flux in their incidence of suicide. There was also no organization that replied to date, as to whether or not they have resources to deal with this issue.

Lake is a mid-range to larger sized county. Most of their suicides though occurring within the older age groups, with the most happening between the ages of 25-34. They also have the problem of disagreement as to whether or not they have resources within the county, or not, to deal with this growing issue. Lake also has the highest number of Native Americans committing suicide in the state (10).

Suicide is an issue that needs to be given recognition in communities. It needs to be known to everyone that there are options, and that that is not a way out. Suicide is selfish and it creates more problems than it solves. Montana may be a small state, but it is very much not immune to issues such as these. We are now at an integral time to step up as professionals and start making a difference in these numbers. This is no longer an issue that can be disregarded or ignored.

TOP CAUSES OF DEATH IN ADOLESCENTS (1995-1998)

	MVA			SUICIDE			FIREARM DEATHS		
COUNTY(YEAR)	10-14	15-17	18-19	10-14	15-17	18-19	10-14	15-17	18-19
Beaverhead (1998)	2	0	1	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	1	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**2**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**
Big Horn (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	1	0	0	0	2	0	0	2
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	1	0	0	2	1	0
Total	**0**	**1**	**0**	**1**	**0**	**2**	**2**	**1**	**2**
Blaine (1998)	0	0	0	1	0	0	1	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	1	0	0	0	0	0	0	0
Total	**0**	**1**	**0**	**1**	**0**	**0**	**1**	**0**	**0**
Broadwater (1998)	0	0	0	0	1	0	0	1	0
(1997)	0	0	0	0	0	0	1	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	1	0	0	0	0	0	0
Total	**0**	**0**	**1**	**0**	**1**	**0**	**1**	**1**	**0**
Carbon (1998)	0	0	1	0	0	0	0	0	0
(1997)	0	1	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	1	0	0	0	0	1	0	0	1
Total	**1**	**1**	**1**	**0**	**0**	**1**	**0**	**0**	**1**
Carter (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cascade (1998)	0	1	0	1	0	1	2	0	1
(1997)	1	1	0	0	0	0	0	0	0
(1996)	0	0	0	0	2	0	0	2	0
(1995)	0	0	0	0	1	0	0	0	0
Total	**1**	**2**	**0**	**1**	**3**	**1**	**2**	**2**	**1**
Chouteau (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	1	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	1	0	0	1	0
Total	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**1**	**0**
Custer (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	1	0	0	1
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	1	0	0	0	0
Total	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**1**
Daniels (1998)	0	0	1	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**
Dawson (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	1	0	0	0	0	0	0
(1995)	0	0	0	0	1	0	0	0	0
Total	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**
Deer Lodge (1998)	1	0	0	0	0	0	0	0	0
(1997)	0	0	1	0	0	0	0	0	0
(1996)	0	0	0	0	1	1	0	1	1
(1995)	0	0	0	0	0	1	0	0	0
Total	**1**	**0**	**1**	**0**	**1**	**2**	**0**	**1**	**1**

COUNTY(YEAR)	MVA			SUICIDE			FIREARM DEATHS		
	10-14	15-17	18-19	10-14	15-17	18-19	10-14	15-17	18-19
Fallon (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	1	1	0	0	0	0	0	0
(1995)	0	1	0	0	0	0	0	0	0
Total	**0**	**2**	**1**	**0**	**0**	**0**	**0**	**0**	**0**
Fergus (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	1	0	0	0	0	0	1
(1996)	0	0	1	0	0	1	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**2**	**0**	**0**	**1**	**0**	**0**	**1**
Flathead (1998)	1	2	1	0	1	0	0	1	0
(1997)	0	1	2	0	1	0	1	0	0
(1996)	0	3	1	0	1	0	0	1	0
(1995)	0	1	1	0	1	0	0	2	0
Total	**1**	**7**	**5**	**0**	**4**	**0**	**1**	**4**	**0**
Gallatin (1998)	0	0	0	0	0	0	0	0	1
(1997)	0	0	1	0	0	0	0	0	0
(1996)	0	0	0	1	0	1	0	0	1
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**1**	**1**	**0**	**1**	**0**	**0**	**2**
Garfield (1998)	0	0	0	0	0	0	1	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**
Glacier (1998)	1	2	1	0	1	0	0	1	0
(1997)	0	0	2	0	0	0	0	0	0
(1996)	1	0	0	0	0	0	0	0	0
(1995)	0	0	1	0	0	0	0	0	0
Total	**2**	**2**	**4**	**0**	**1**	**0**	**0**	**1**	**0**
Golden Valley (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Granite (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Hill (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	2	0	0	0	0	0	0	0
(1996)	0	0	0	1	0	0	1	0	0
(1995)	2	1	1	0	1	0	0	1	0
Total	**2**	**3**	**1**	**1**	**1**	**0**	**1**	**1**	**0**
Jefferson (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Judith Basin (1998)	1	1	0	0	0	0	0	0	0
(1997)	0	0	1	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**
Lake (1998)	0	1	0	0	1	0	0	0	1
(1997)	0	0	0	0	0	1	0	0	1
(1996)	1	1	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**1**	**2**	**0**	**0**	**1**	**1**	**0**	**0**	**2**

COUNTY(YEAR)	MVA			SUICIDE			FIREARM DEATHS		
	10-14	15-17	18-19	10-14	15-17	18-19	10-14	15-17	18-19
Lewis and Clark (1998)	0	3	1	0	1	0	0	0	0
(1997)	0	0	2	0	1	0	0	1	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	1	0	0	0	1	0	0	1
Total	**0**	**4**	**3**	**0**	**2**	**1**	**0**	**1**	**1**
Liberty (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	1	0	0	0	0	0	0	0	0
Total	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Lincoln (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	1	1	0	0	0	1	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**1**	**1**	**0**	**0**	**0**	**1**	**0**	**0**
McCone (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Madison (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	1	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	1	0	0	0	0	0	0
Total	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**
Meagher (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Mineral (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	1	1	0	0	0	0	0	1
Total	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**1**
Missoula (1998)	0	1	1	0	0	0	0	0	0
(1997)	0	1	1	0	0	0	2	0	0
(1996)	0	1	1	0	1	1	0	1	0
(1995)	0	1	2	0	2	0	1	2	0
Total	**0**	**4**	**5**	**0**	**3**	**1**	**3**	**3**	**0**
Musselshell (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Park (1998)	0	0	0	0	0	0	0	0	1
(1997)	0	0	0	0	1	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**
Petroleum (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Phillips (1998)	0	1	1	0	0	0	0	0	0
(1997)	0	1	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**2**	**1**	**0**	**0**	**0**	**0**	**0**	**0**

	MVA			SUICIDE			FIREARM DEATHS		
COUNTY(YEAR)	10-14	15-17	18-19	10-14	15-17	18-19	10-14	15-17	18-19
Pondera (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Powder River (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	2	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Powell (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Prairie (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Ravalli (1998)	1	0	0	0	0	0	0	0	0
(1997)	0	1	1	0	1	0	1	1	0
(1996)	1	1	0	0	1	0	1	2	0
(1995)	0	0	1	0	0	0	0	0	0
Total	**2**	**2**	**2**	**0**	**2**	**0**	**2**	**3**	**0**
Richland (1998)	0	1	1	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**
Roosevelt (1998)									
(1997)									
(1996)									
(1995)									
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Rosebud (1998)	0	1	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	2	1	0	0	1	0	0
(1995)	0	1	1	0	1	0	0	1	0
Total	**0**	**2**	**3**	**1**	**1**	**0**	**1**	**1**	**0**
Sanders (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	1	0	0	0	0	0	0	0
(1996)	0	0	1	0	0	0	0	0	0
(1995)	0	1	0	0	0	0	0	0	0
Total	**0**	**2**	**1**	**0**	**0**	**0**	**0**	**0**	**0**
Sheridan (1998)	2	1	0	0	1	0	0	1	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	1	0	0	1	0
Total	**2**	**1**	**0**	**0**	**2**	**0**	**0**	**2**	**0**
Silver Bow (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	1	0	0	2	0	0	0	1
(1996)	0	0	0	0	0	1	0	0	1
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**1**	**0**	**0**	**2**	**1**	**0**	**0**	**2**
Stillwater (1998)	0	1	0	1	0	0	1	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	1	0	0	1
(1995)	0	0	0	0	0	0	0	0	0
Total	**0**	**1**	**0**	**1**	**0**	**1**	**1**	**0**	**1**

	MVA			SUICIDE			FIREARM DEATHS		
COUNTY(YEAR)	10-14	15-17	18-19	10-14	15-17	18-19	10-14	15-17	18-19
Sweet Grass (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	•	•	•	•	•	•	•	•	•
Teton (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	1	0	0	1
Total	•	•	•	•	•	1	•	•	1
Toole (1998)	0	0	1	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	•	•	1	•	•	•	•	•	•
Treasure (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	•
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	•	•	•	•	•	•	•	•	•
Valley (1998)	0	0	1	0	0	0	0	0	0
(1997)	0	0	0	0	1	0	0	1	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	1	0	0	0
Total	•	•	1	•	1	1	•	1	•
Wheatland (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	•	•	•	•	•	•	•	•	•
Wibaux (1998)	0	0	0	0	0	0	0	0	0
(1997)	0	0	0	0	0	0	0	0	0
(1996)	0	0	0	0	0	0	0	0	0
(1995)	0	0	0	0	0	0	0	0	0
Total	•	•	•	•	•	•	•	•	•
Yellowstone (1998)	0	2	2	1	0	1	0	0	1
(1997)	0	1	1	0	2	0	0	2	0
(1996)	1	0	1	0	0	1	0	1	2
(1995)	0	3	0	0	2	2	0	2	0
Total	1	6	4	1	4	4	•	5	3

Key City: Reservations:	STATE	MACO 1 Glascow Ft. Peck	MACO 2 Glendive	MACO 3 Miles City N. Cheyenne	MACO 4 Havre Ft. Belknap Rocky Boy's	MACO 5 Great Falls Browning	MACO 6 Lewistown	MACO 7 Billings Crow	MACO 8 Helena	MACO 9 Bozeman	MACO 10 Kalispell Salish/Kootenai	MACO 11 Missoula	MACO 12 Butte
Alcohol Sales Outlets per 1,000	3.47	4.88	3.98	3.96	3.47	3.39	4.93	2.59	3.16	3.65	3.6	2.68	5.32
Alcohol Beverage Tax	418.24	97.95	407.02	378.5	379.61	405	369.06	356.97	396.48	418.24	489.96	445.21	439.89
Vandalism (age 10 - 14) rate	6.15	6.1	4.25	3.58	16.02	2.3	5.25	2.66	7.65	3.38	11.32	7.62	7.74
Alcohol Related Arrests (age 10 - 14) rate	1.8	1.43	0	1.07	1.6	1.25	0	0	6.35	0.38	4.78	0.21	2.82
Personal and Property Crime (age 10 -14) rate	41.73	20.09	33.89	30.46	73.29	13.36	37.8	31.24	56.56	37.02	64.04	50.73	54.36
Juvenile Alcohol related Arrests rate	7.95	3.31	1.62	5.58	6.59	2.88	0.64	1.02	26.04	1.64	23.28	1.17	12.23
Juvenile Drug related Arrests rate	8.68	2.65	2.7	12.46	6.85	1.51	4.83	9.63	16.54	10.33	9.57	12.49	4.63
Juvenile Violent Crimes Arrests rate	1.27	0	0	1.07	1.27	0	1.61	0.53	2.84	1.88	1.89	2.08	1.54
Juvenile Arrests Vandalism/Disorderly rate	14.48	9.27	14.07	12.02	31.7	4.52	10.96	6.58	18.31	11.24	21.21	22.45	19.82
Juvenile Property Crime Arrests rate	50.96	21.41	46.25	40.58	84.2	12.38	39.96	43.35	72.32	48.73	74.65	65	57.1
Adolescent Pregnancies	12.79	13.41	6.49	14.07	16.86	16.93	10.8	14.7	10.89	11.07	11.82	10.43	8.3
	HIGH	1		2	5	1	1		6	1	7	6	4
All rates are per 1,000	LOW	6	5	4	1	6	4	5	0	3		2	2

Some rates are a rolling average to address small numbers problems

There are 11 indicators here. Six is more that 1/2

Youth Intentional Injury/Suicide rate and method: 12/98-12/99						
Date of Death	Age	Race/ Ancestry	Sex	County of Residence	Cause of Death	Autopsy
12/19/98	16 years	White	M	Lake	Suicide- gunshot wound to head	No
12/21/98	14 years	White	M	Cascade	Suicide/ Hanging	Yes
12/27/98	17 years	Mex/ Irish/ Polish	F	Sheridan	Suicide/ Hanging	No
2/15/99	14 years	White	M	Madison	Suicide Gunshot to Head	No
5/18/99	15 years	White	M	Mussell shell	Suicide Gunshot to Head	yes
7/2/99	17 years	White	M	Hill	Suicide gunshot to head	no
7/15/99	17 years	White	M	Granite	Suicide gunshot to head	no
7/31/99	15 years	White	M	Flathead	Suicide gunshot to head	no
8/26/99	13 years	White	M	Rosebud	Suicide Gunshot to head	yes
9/10/99	17 years	Native American/ Assiniboine	M	Blaine	Suicide Gunshot to head	no
10/5/99	17 years	White	M	Cascade	Suicide Gunshot to head	no

Youth Intentional Injury/Suicide rate and method: 12/98-12/99						
Date	Age	Race	S	County	Cause of Death	Autopsy
10/25/99	14 years	Native American	M	Cascade	Suicide Gunshot to head	No
11/5/99	13 years	Wh te	M	Yellow-stone	Suicide gunshot to head	yes

APPENDIX G

APPENDIX G

NEEDS ASSESSMENT: DOMESTIC VIOLENCE (WOMEN OF CHILDBEARING AGE)

Domestic violence has become a significant issue in the state of Montana. There have been several things done within the past few years that will help to combat this problem. The Montana Coalition against Domestic and Sexual Violence (MCADSV) is continuing to help women in the state in many ways. Recently, the Montana Domestic Violence Batterer's Intervention Program (MDVBIP) has created an advisory panel to create standards for batterer's intervention programs to comply with. There have also been a couple of surveys that have been done regarding domestic violence within the state. Montana takes this issue very seriously, and has even begun to monitor the counties that consistently screen their patients for domestic violence, with one of their state negotiated performance measures within the MCH Block Grant.

When dealing with Maternal and Child Health (MCH), it is sometimes easier to relate the problem as it is dealt with in terms of the MCH pyramid. The following table is a summary of how domestic violence is dealt with in the state of Montana, with reference to either the resources available, or where the need arises, focusing on pyramid levels.

Direct Services	Agencies that provide shelter, services, counseling, etc.
Enabling Services	Agencies that provide transportation, translation, advocacy in many ways or areas related to domestic violence
Population-Based Services	Campaigns to make communities aware of hotlines, the issue, etc., surveys
Infrastructure Building	Coordination between agencies, quality assurance, evaluation of existing programs, needs assessment of agencies, public policies, technical assistance, etc.

DIRECT SERVICES

There are several agencies in Montana that provide shelter, counseling, and other services to the victim as well as the batterer. The Montana Coalition against Domestic and Sexual Violence (MCADSV) not only provides a hotline for victims of abuse to call (1-800-655-7867), but a variety of other services that directly assist the victim. They are very willing to help the victim get in contact with any resource that she may need to either get out of the situation or alleviate it in some manner. Their mission is to "strive to ensure that alternatives are available to victims of domestic and sexual violence in all rural, urban, and tribal communities." They currently serve 55 of the 56 counties in Montana, which includes providing safe homes, shelters, and forty hotlines.

The Fort Peck Tribes Crisis Center in Wolf Point, Montana also provides shelter, counseling, and assistance in any manner possible for Native American women in this area trying to leave an unsafe environment. A part of this agency also works with The Family Preservation Program to provide "intensive, culturally relevant, outreach services to Ft. Peck families" who may need assistance with dealing with domestic violence.

According to the 1998 AHA Annual Survey of the 56 hospitals within the state of Montana, three hospitals provide a crisis prevention program. One has a program provided by a health system within the community, two have a program provided by a community network, and one has a formal contractual agreement with another provider that is not in the same network or system. Therefore, it is quite easily noticed that hospitals in the state tend to veer away from the crisis prevention programs. Whether that has anything to do with lack of resources or time is of another issue.

ENABLING SERVICES

Once again, the MCADSV serves to be one of the largest advocacy agencies in the state that deals with the issue of domestic violence. They also provide training programs for professionals that want to learn more about domestic violence in their communities.

The Fort Peck Tribes Crisis Center also deals with advocacy for Native American women.

POPULATION-BASED SERVICES

The MCADSV mans a hotline that is available for all the state of Montana—forty hotlines in all. There are hotlines for English, Spanish, Korean, Pakistan, Nepal, Sri Lanka, and Indian speaking women. The following is a table of the amount of calls the hotline received between June 1, 1996 and May 31, 1997, and what subject area they were calling about.

CALL SUBJECT	TOTAL
Sexual Assault	85
Domestic Violence	214
Stalking	13
Elder Abuse	2
Sexual Abuse/Child	17
Child Abuse	21
Other	69
Total	421

The following table is who placed calls to the Hotline from June 1, 1996 through May 31, 1997. For a list of the exact number of calls from each county, see Appendix A.

CALLER	TOTAL
Primary Victim	193
Secondary Victim	185
Perpetrator	7
Other Caller	37
Total	422

The Coalition also provides community education and awareness programs throughout the state. They have a speaker's bureau of professionals that are available to provide community education programs for those interested. They currently have two comprehensive media campaigns in Montana—Domestic Violence Awareness Month in October, and Love Without Fear Week in February.

Several surveys have been done within the last year that have also provided a more comprehensive view of domestic violence within the state. The first was asked on a pre-contract survey that the counties had to fill out before MCHBG funds were distributed. This question helps to monitor one of Montana's state negotiated performance measures. It was determined that in 1998, approximately 51% of counties currently screen their patients for domestic violence, and 78% have resources for referral for their patients.

A screening tool (RADAR cards) was given out at a public health nurse's conference the previous year. Radar cards are small cards that a practitioner can carry with them that remind them to ask every patient if she is a domestic violence victim or not, and then how to handle different situations, and resources for the women.

There were also several questions on a survey for MIAMI (Montana's Initiative for the Abatement of Mortality in Infants) patients. These women have higher risk pregnancies and are put into this home visiting program; to hopefully curb some of the excess risk associated with their pregnancy. Unfortunately, pregnant women are also at a higher risk for becoming victims of domestic violence. In 1998, approximately 7% of the women were presently in an abusive relationship, and 31% had a history of being in an abusive relationship.

The medical officer of the state, Dr. Michael Spence, completed the largest survey done to date thus far in the state of Montana on domestic violence. He sent 3000 surveys to various health clinics, WIC clinics, doctor's offices, and any other interested organization. So far, 1970 have been analyzed, with rather staggering results. The results were not more highly predictive in areas such as

age, race, or an urban/rural living situation for women dealing with emotional abuse within the past year. For those dealing with physical abuse, it was more predictive in the younger age brackets, with less education, and drug use, but not for any of the other characteristics. For the question, "Within the past year, have you been hit, slapped, kicked, raped, or otherwise physically hurt by someone," 46% of women responded yes, with 83% of the perpetrators being either a former or current spouse or boyfriend, 79% of the time taking place within the home. For those women experiencing emotional abuse within the last year, 24% had had suicidal thoughts. For those women experiencing physical abuse within the last year, 31% had had suicidal thoughts. Unfortunately, because this was a self-reported survey, the numbers may even be higher than this. Domestic violence is very much a threat to Montana's women.

INFRASTRUCTURE BUILDING

The two key agencies for infrastructure building activities within the state, are once again the MCADSV and the MDVBIP. The Coalition provides comprehensive assessment of programs within the state. These services include, but are not limited to: Consultation by phone, resource library clearinghouse, professional training teams, on-line research, on-site visitations, and specialized training sessions.

Another purpose of the MCADSV is to set a standard for public policy. They assist the legislative branch by providing expert testimony and sitting on decision-making committees, in essence becoming the voice of battered women in Montana.

A very important service of the Coalition is to provide networking opportunities for other domestic violence programs within the state. They provide this through statewide meetings and training sessions. They also produce a monthly bulletin and a quarterly newsletter. They also represent Montana programs in national entities and programs. The staff serves on caucus and special interest groups across the country.

The MDVBIP is a panel of practitioners and experts from related fields that have come together to provide standards for court-ordered intervention programs for batterers. By doing this, they have established a quality assurance standard and purpose for these intervention programs. One thing that is important that they have advocated is assessment and evaluation of these programs, to be completed by an outside source. These assessments will measure who would benefit from such a program, where referrals for alcohol and drug rehabilitation are needed, those who need professional mental help, and to elicit information that may help compile a more appropriate psychological profile of an abuser.

OTHER PROGRAMS

According to the American Journal of Psychiatry, violent youth are four times more likely to come from homes in which they witness domestic violence than

are nonviolent youth. The Montana Behavioral Initiative (MBI) seeks to improve the capacity of schools, and to provide a proactive effort to identify community priority concerns, especially those related to violence. It truly looks at what prevention is, and believes that in order to prevent violence; intervention must be made at the absolute first precursor of negative behavior. This is especially true for those young adults that have witnessed violence in the home. A program like MBI will identify those negative behaviors, and then accepts the opportunity to teach the student to substitute positive behaviors for negative ones. One of their key belief statements is one that many communities should take to heart in order to truly eliminate violence: "Positive, proactive and preventative efforts of schools and communities can defeat violence."

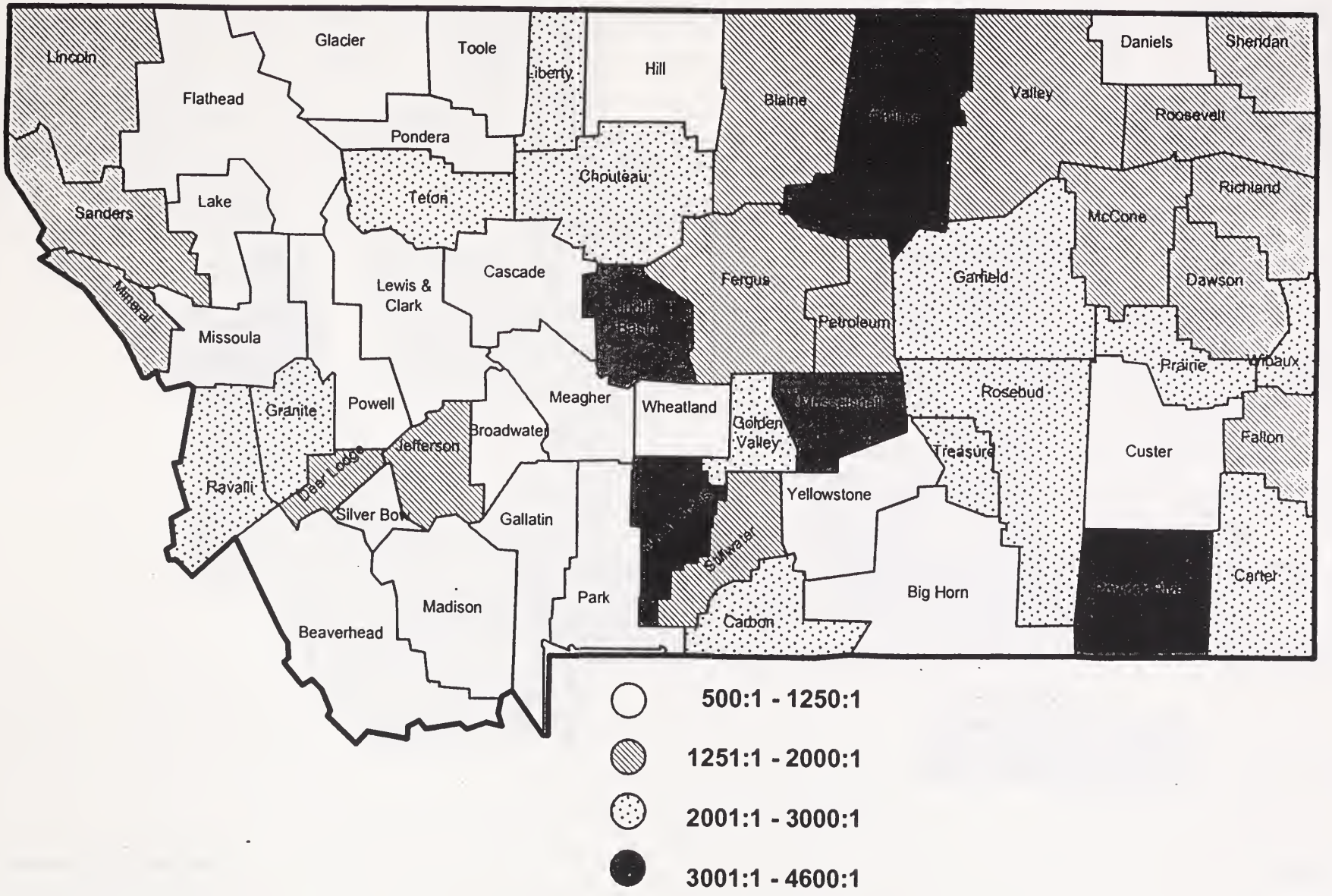
CONCLUSION

There are several organizations and programs within Montana that hope to combat domestic violence. There also are a lot of women though, who do not reach out to these organizations and programs, who are suffering. Too many fall through the cracks of health care, churches, or other areas that should offer help to the wounded. Numbers do suggest that domestic violence is an issue within the state, but there are still those individuals who choose to believe that a small rural state like Montana should not, and absolutely could not have a problem with this issue. It is the job of public health professionals and advocates across the state to make this issue foremost on the minds of individuals who are in the position to effectively make changes.

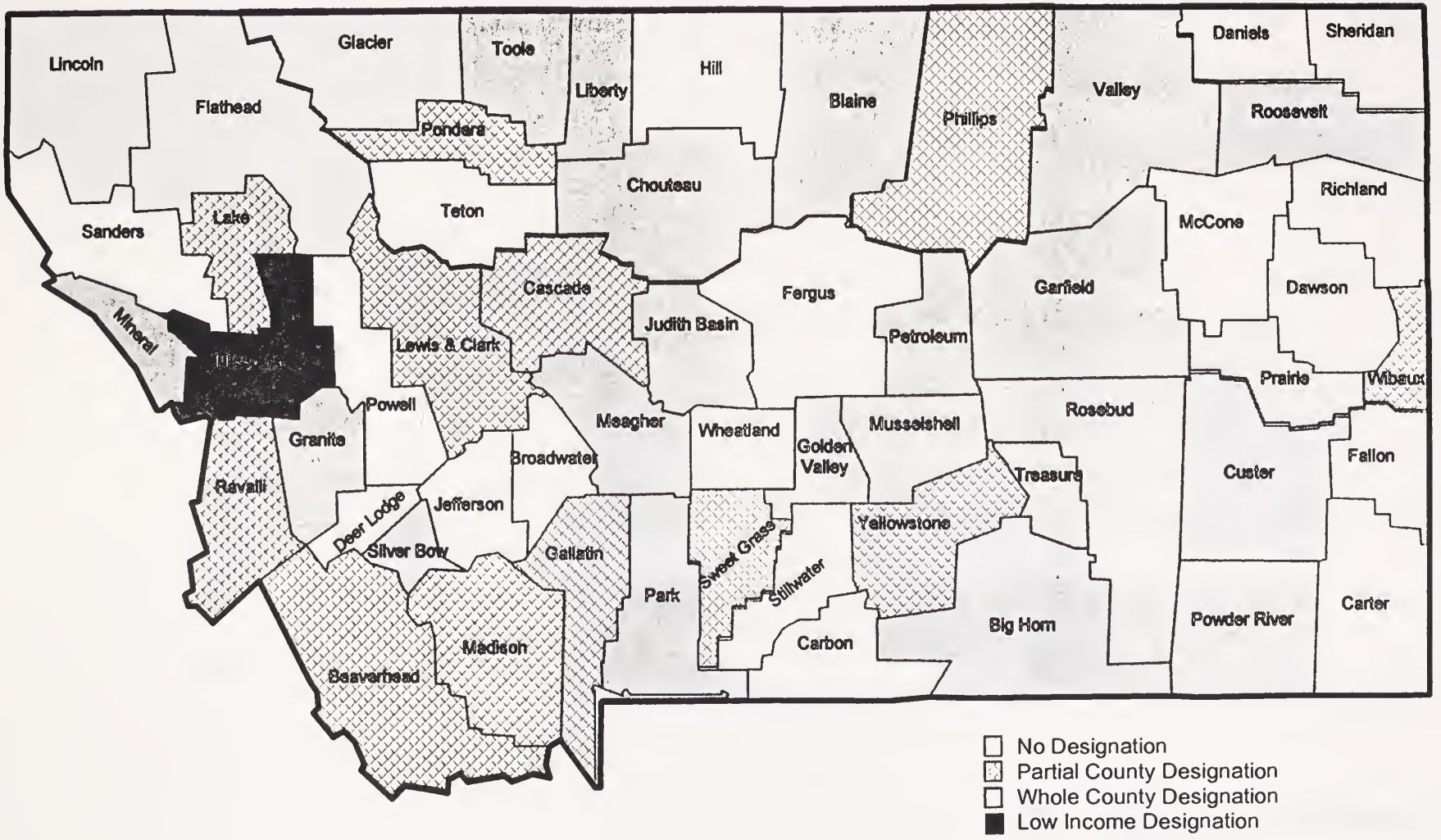
APPENDIX H

Montana Population to Primary Care Physician Ratios

1998 MMA Data



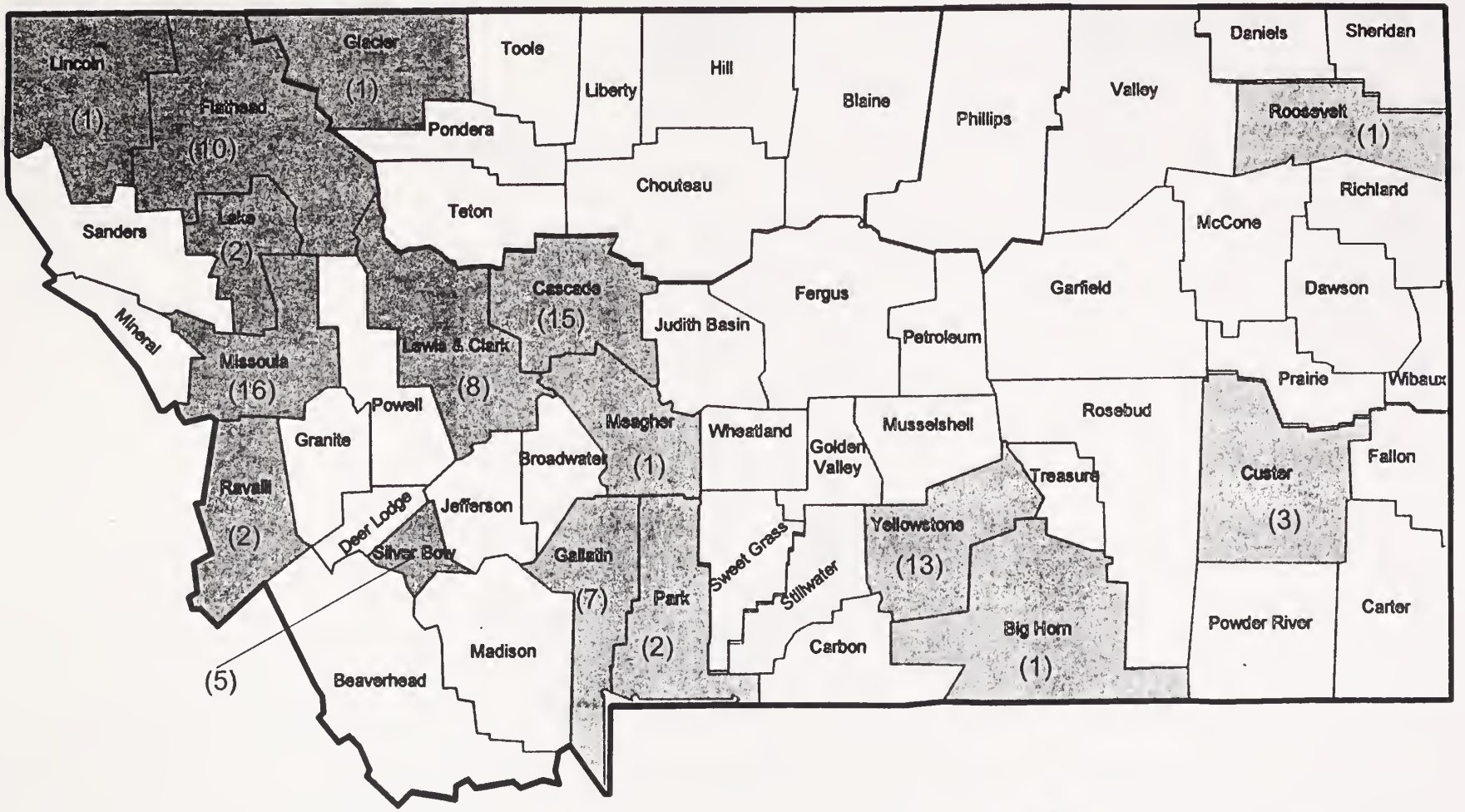
Medically Underserved Areas/Populations of Montana
December 3, 1999



(Montana Primary Care Office)

01/05/2000

PEDIATRICIANS IN MONTANA

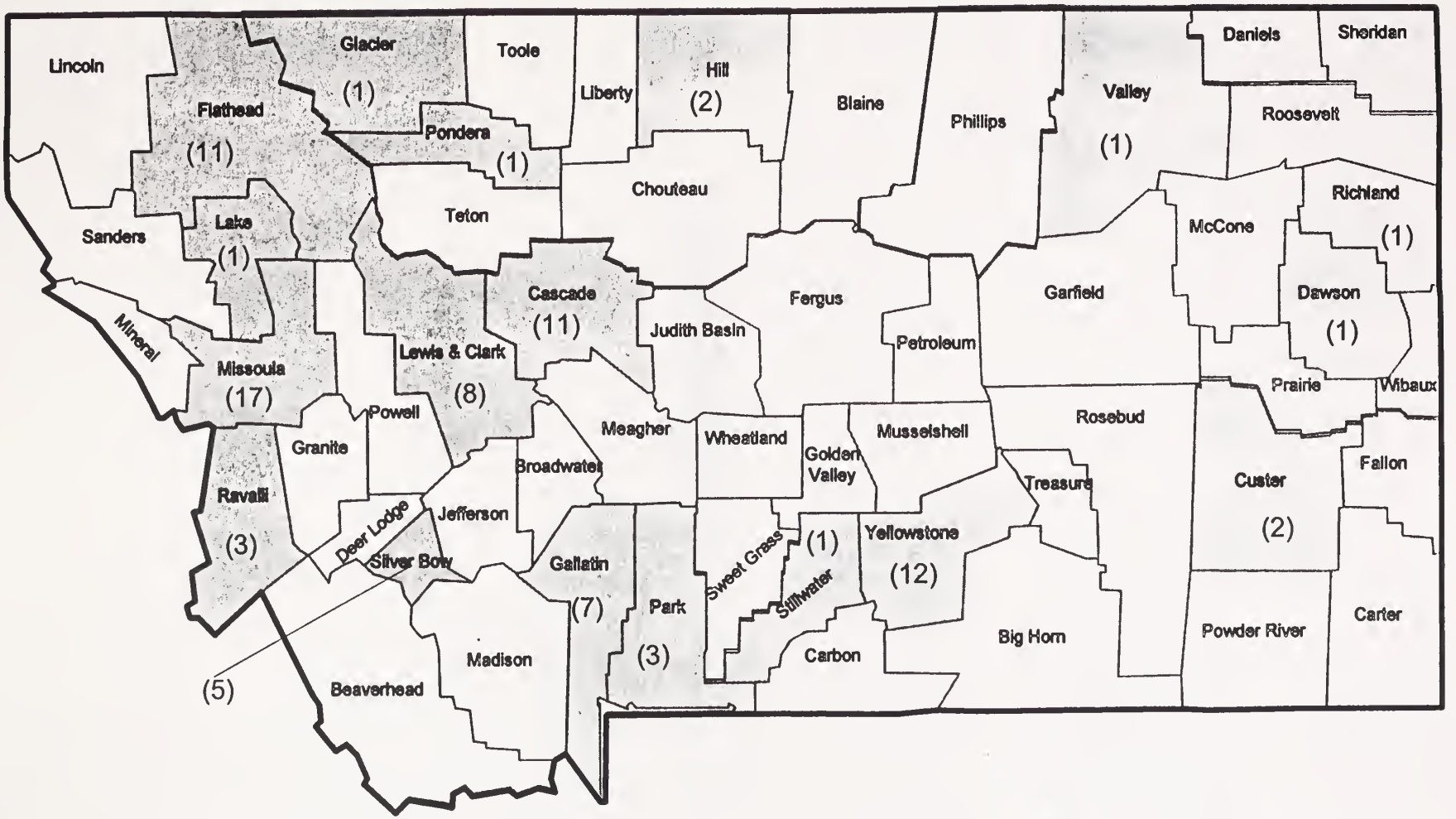


Counties with Pediatricians
Total= 88
(includes sub-specialties)

Data from: 1999 MMA Directory
(Montana Primary Care Office)

01/04/2000

OB/GYN's IN MONTANA



Counties with OB/GYN's
Total= 88
(includes sub-specialties)

Data from: 1999 MMA Directory
(Montana Primary Care Office)

01/04/2000

APPENDIX I

Montana Department of Public Health and Human Services
Women's Health Section

Montana Pregnancy Risk Line Evaluation

Background. Since 1986, the Montana Pregnancy Risk Line (PRL) has provided teratology information to health care providers and the public. The PRL is a telephone service (operating Monday through Friday between 8:30 am and 4:30 pm) designed to provide accurate and current information about the effects of environmental exposures on pregnancy outcome and breast-fed infants. Staff and medical consultants to the PRL review and evaluate current literature in human teratology and lactation to summarize for callers. A data review for the PRL indicates that during the January, 1994 to June, 1998 time period, 70% of the calls were from pregnant women and 30% of the calls were from health care professionals.

The Women's Health Section mailed 444 surveys to practicing OB/GYN (N=85) and Family Practice physicians (N=359) throughout Montana to determine awareness and use of the PRL. The mailing list was obtained by the Montana Medical Association (MMA) list of practicing physicians in the state and included both members and non-members of the MMA.

Survey Respondent Demographics.

Type of Practice		**Number of Pregnant Women Seen Annually**	
Family Practice Physician	129 (67%)	Less than 12 patients	25 (17%)
OB/GYN Physician	43 (22%)	Between 12 and 49 patients	50 (52%)
Emergency Room Physician	14 (7%)	More than 50 patients	69 (48%)
Nurse Practitioner	4 (2%)		
Missing	2 (1%)		
TOTAL	192	TOTAL	192

Survey response rate was 43%. A greater percentage of OB/GYN physicians responded to the survey when compared to Family Practice physicians (39.8% compared to 50%, respectively) Survey respondents reported practicing in 57 different locations in Montana. The most common city of practice included Missoula (11% of respondents), Billings (9.8%), Bozeman (8%) and Kalispell (6.6%). Sixty percent of respondents practiced in rural areas, defined as a city with less than 10,000 residents. Eleven percent practiced in cities with between 10,000 and 24,999 residents and 29% practiced in cities with more than 25,000 residents.

Survey Questions.

What do you know about the Pregnancy Risk Line? N=189

Pregnancy Risk Line provides information about environmental exposures and pregnancy outcome	50 (27%)
Hours of operation	14 (7%)
Pregnancy Risk Line is toll-free	40 (21%)
I was not aware of the Pregnancy Risk Line	139 (74%)

Do you use the Pregnancy Risk Line?

152 (80%) NO

39 (20%) YES (please check all the ways you use this service)

I call the risk line myself for consultation	27 (69%)
I give the risk line phone number to patients who call with questions that I cannot answer	28 (72%)
I give the risk line phone number to patients when I am not available to answer questions	15 (39%)
I have office staff provide the risk line number to patients who call with questions	26 (67%)
I provide the risk line brochure in OB packet	9 (23%)
I post the risk line information in the office	14 (36%)
Other	2 (5%)

Who uses the Pregnancy Risk Line?

Family Practice Physicians: 10% of those surveyed report use (n=128)
OB/GYN Physicians: 46.5% report use (n=43)
Nurse Practitioners: 100% report use (n=4)
ER/ Urgent Care Physicians: 16% report use (n=14)

Providers seeing <12 pregnant women per year: 9% of those surveyed report use (n=100)
Providers seeing 12-49 pregnant women per year: 14% report use (n=50)
Providers seeing >50 pregnant women per year: 36% report use (n=69)

Provider practicing in small town (<10,000 pop.): 8% report use (n=109)
Provider practicing in medium town (10,000 -24,999 pop.): 67% report use (n=21)
Provider practicing in large town (>25,000 pop.): 26% report use (n=53)

If you use the Pregnancy Risk Line, what do you like about the service? (Please check all that apply) N=39

The risk line provides accurate and current information	34 (87%)
Patients can access the information themselves	31 (74%)
The risk line identifies factors to improve the health of infant or child	22 (56%)
The risk line provides reassurance to women about the health of the infant or child	26 (70%)
The risk line decreases the demands for screening and testing of the in utero exposed infant and child	10 (26%)
The risk line allows for efficient use of my time	31 (79%)
Other	6 (15%)

Could you obtain the information about environmental risks to a fetus or breast-fed infant through the following: (check all that apply) N=109

Information available on the Internet	61 (56%)
A toll free number provided tape recordings of answers to the most frequently asked questions, with an option to talk to a counselor	33 (30%)
Poison Control Line	39 (36%)
Other	22 (20%)
I would not change the Pregnancy Risk Line	37 (34%)

How could the services provided by the Pregnancy Risk Line could be improved? N=58

Increase awareness of the PRL through advertising, posters and public service announcements	36 (62%)
Increase accessibility with longer hours of operation	3 (5%)
Have a PRL web site so that questions can be e-mailed to staff	1 (2%)
Need more information on herbal and alternative medicine	1 (2%)
Use poison control hotline to provide this service	1 (2%)
Would not change the PRL	8 (24%)
Wasn't aware of PRL - Don't know how to improve	7(12%)

Comments.

- Among the health care providers surveyed, awareness and use of the Montana Pregnancy Risk Line (PRL) is low:
  - → 26% of respondents were aware of the PRL
  - → 20% of respondents use the PRL

- Among those who use the PRL:
  - → the use increases as the number of pregnant patients seen annually increases
  - → compared to other physicians, a greater percentage of OB/GYN's report using the PRL

- Those who use the PRL report benefits:
  - → The majority of users (87%) report that the PRL provides accurate and current information; allows for efficient use of time (79%); and that patients can access information themselves (74%)
  - → The majority of users (79%) would not change the PRL.

- More than half (56%) of survey respondents report that information about environmental risks to a fetus or breast-fed infant is available on the Internet.

- How can the PRL be improved?
  - → The majority of survey respondents (62%) suggested increasing awareness of the PRL through advertising, posters and public service announcements.

Pregnancy Risk Line (PRL) Evaluation Progress Report
Women's Health Section

1. MONTANA PREGNANCY RISK LINE DATA REVIEW

Data Available

Montana data was available from the Utah Pregnancy Risk Line from 1992-June 30, 1998.

Missing data
1992- 3 month missing
1993-6 months missing
1998-have requested and not received 7/98- 12/98

Data Reviewed
Data was review from January 1,1994 to the June 30, 1998 (4.5 years)

A. IDENTIFICATION OF PREGNANCY RISK LINE USERS

✦70% of calls received were from "consumers" (public) who represented themselves and were pregnant. (We do not know if some of these pregnant consumer phone calls were referred by the medical providers)

✦30% of calls received were from professionals
Professionals include the following categories : 1) ob/gyns; 2) pediatricians; 3)other medical doctors; 4) CNMs; 5) nurse practitioners; 6) other nurses, 7) physician assistants; 8) pharmacists; 9) genetic counselors; 10) clinical personnel; 11) and other professionals.

✦There was no criteria available to determine definitions for "other nurses" and "clinic personnel."

✦Consistently OB/GYNs and "other nurses" have been heavy users of the Risk line. Although since 1996 the use of risk line by "other nurses" has declined.

✦"Other MD" use of Risk line has decreased consistently since 1996.

✦CNMs, and NPs have significantly increased their use, doubling from 1997 to projected 1998 statistics.

B. QUANTITY OF MONTANA PREGNANCY RISK LINE CALLS

largest number of call received --1996- 1064
Smallest number of calls received --1994--742
Projected number for 1998- 934

C. LOCATION OF MONTANA PREGNANCY RISK LINE CALLS

Locations included: Billings, Bozeman, Missoula, Helena, Great Falls, Butte, Kalispell, and "Other MT".

✦The largest number of calls have been consistently received from Bozeman , the second largest number from Missoula. The third largest number from Billings although this number is half the amount of Missoula's calls.

✦Since 1996 Billings, Butte, Kalispell and Great Falls have decreased or barely maintained the same number of calls.

✦Other MT calls more than doubled between 96 and 97 and are projected to increase for 1998.

D. COST OF MONTANA PREGNANCY RISK LINE CALLS

1997 Cost = grant $20,000
marketing (development, printing and distribution of flyer) = ?
State personnel time for contract managment not included

Cost per call based on 853 calls in 1997 = $23.44/call

2. ACTION PLAN

A SURVEY

purpose
✦Identify awareness of PRL
✦Identify use of PRL by providers
✦identify providers' opinions for PRL improvement
✦Identify other means of providing PRL services

target population

Involvement of others

B. Other data necessary for ongoing evaluation

✦Review of PRL information gathered for each call (e.g. what topics to callers request information about?)

✦Client satisfaction survey

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